# MEDICARE HOSPITAL DRG MARGINS

## HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

## COMMITTEE ON WAYS AND MEANS
## HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

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FEBRUARY 26, 1987

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**Serial 100-17**

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Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

72-423 WASHINGTON : 1987

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

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# MEDICARE HOSPITAL DRG MARGINS

THURSDAY, FEBRUARY 26, 1987

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
*Washington, DC.*

The subcommittee met, pursuant to notice, at 10:02 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
THURSDAY, FEBRUARY 12, 1987

PRESS RELEASE #1
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
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# THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON MEDICARE HOSPITAL DRG MARGINS TO BE HELD ON THURSDAY, FEBRUARY 26, 1987

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The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee will hold a hearing on the issue of Medicare hospital Diagnosis Related Group (DRG) margins on Thursday, February 26, 1987, beginning at 10:00 a.m., in room B-318 Rayburn House Office Building.

In announcing the hearing, Chairman Stark stated, "Both the Congressional Budget Office (CBO) and the Prospective Payment Advisory Commission (ProPAC) have now completed their analysis of hospital DRG margins in 1984, the first year the DRG system was operational. These studies, which show margins of over 15 percent in 1984, raise questions regarding the level of payments to hospitals under the DRG system."

The Subcommittee hearing will provide a forum for the presentation of the CBO study as well as comments by ProPAC. It will also allow hospital representatives a chance to present their views. Other witnesses will discuss the effect of the DRG system on the quality of medical care received by elderly and disabled.

## BACKGROUND

The prospective payment system (PPS) was adopted by Congress in 1983 as the method of hospital payment for Medicare. Four hundred and seventy-one Diagnostic Related Groups are used to classify each hospital admission. The DRGs are based on the principal diagnosis that resulted in the admission of the patient to the hospital. The DRG system allows for additional payments in certain situations where there are secondary diagnoses or com icating conditions. Hospitals are paid a unit price based on the DRG classification as determined from the medical record. Urban and rural differences in the costs of medical care are partially accounted for in the DRG methodology.

-MORE-

Since PPS was initiated, there has been some concern about the equity of this reimbursement method. Limited studies by the Inspector General for the Department of Health and Human Services have shown that Medicare DRG payments to hospitals exceed medicare costs by an average of 15 percent. The Congressional Budget Office has recently completed a study to determine Medicare margins for all hospitals under the DRG system. The results of this study will be presented at this hearing.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, March 20, 1987, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE ENCLOSED FORMATTING REQUIREMENTS

*****

Chairman STARK. Good morning. The Subcommittee on Health will begin.

We welcome a number of distinguished witnesses as we begin considering issues raised by the 1988 budget reconciliation legislation.

In 1983, we adopted legislation that instituted diagnosis-related groups. They are better understood now, but we also understand the imperfections that we adopted in order to begin. In particular, we agreed back then to base the DRG rates on hospitals' costs in 1981, although we assumed that procedures would become more efficient, and that was probably a high cost.

We agreed, also, to use broad and inevitably inaccurate assumptions to project costs ahead to 1984 and to accept rough estimates of the increases in costs due to the changes from year to year.

Now, 4 years later, the actual data documenting the results of the changes are available. The analysis of that data shows that the imperfections of the system accepted as necessary in 1983 resulted in a variety of effects. Among those are DRG hospital margins estimated at an average of 12 percent. These higher margins are not the result of inappropriate, let alone improper, actions on the part of hospitals; they are simply the result of the implementation and operation of the DRG system as it was designed.

Whatever their origins, the margins appear high. They raise four questions: What is the most reasonable estimate of the DRG margins in 1988 and subsequent years? Are these reasonable average hospital margins? If appropriate, what is the best and most equitable method to reduce hospital payments and DRG margins and what use should be made of the funds made available due to any reduction in hospital payments?

The first two questions are important. Judgments about the 1984 data and projections to 1988 will be necessary, and it is unlikely there will be a ready consensus on hospital DRG margins in 1988.

The third question is more complex. Even if an agreement can be reached about a surplus, decisions about adjustments to DRG rates will be difficult. Any reduction in Medicare payments will inevitably threaten some hospitals, particularly those in rural communities and inner-city neighborhoods.

The answer to the last question is the most critical: What use should be made of any funds available due to a reduction in hospital payments? The hospital prospective payment system has resulted in a significant increase in costs to the elderly and the disabled since 1983.

There are two particularly obvious effects: First, the hospital deductible has increased by $175 more than if the 1983 deductible had merely increased at the rate of inflation in the general economy. The higher deductible will cost beneficiaries an additional $1.5 billion in 1987.

The elderly have lost more than cash due to the DRG system. They have lost coverage for 21 million days of care each year due to the nearly 2-day decrease in the length of the average hospital stay. These beneficiaries transferred to their homes quicker and must now cope with medical needs and more ordinary tasks without the nursing care and other assistance available in the hospital.

Medicare, of course, does not cover these services in the home as it was not designed for an era of shorter hospital stays.

In short, if any funds are available from justifiable refinements to the DRG system, it is this person's opinion that they should be used to offset the increased costs that the elderly and disabled have experienced as a result of the payment system. A balance between budget savings and policies to support our elderly and disabled, such as a reduction in the hospital deductible and better coverage of post-hospital services, is my goal as we consider the reconciliation legislation.

Mr. Gradison?

Mr. GRADISON. Thank you, Mr. Chairman. I am happy to join with you in your opening statement, which sets out the concerns that lead to this hearing.

For myself, I would like to indicate that my intentions are to focus on the future and not the past. What may have happened in 1984 or 1985 is all very interesting, but we are in the process of working out budgets for the future, and I think that should be the focus of our attention.

My second and only other major point is that the more I study the way in which the DRG system has developed—indeed, the way all the reimbursement mechanisms are developing under both part A and part B—I am deeply concerned about a growing lack of trust among the people who are involved in this: the Federal Government suspicious of hospital margins; hospitals complaining that we are changing the rules in the middle of the game; many actions which we have taken because we don't think the administration is following the statute; many actions taken by the administration because of certain budgetary concerns which they quite properly have.

So, just to conclude, I think we properly are discussing numbers, but they ought to focus on the future, not the past. There are intangibles dealing with a sense of whether we are going to have a "heads-I-win, tails-you-lose" approach to this or whether we are going to have something that I hope can begin to rebuild what I think is a very seriously damaged trust level among all of us who are involved in this process.

Thank you, Mr. Chairman.

Chairman STARK. Are there any other members who would like to comment or make a statement? [No response.]

[Mr. Moody submitted the following opening statement:]

HON. JIM MOODY STATEMENT ON DRG OPERATING MARGINS

Mr. Chairman, I commend you for holding today's hearing on hospital operating margins under the Prospective Payment System.

The President's budget for fiscal year 1988 once again calls for increased defense spending and substantially reduced non-defense spending. The Medicare program is targeted for the largest spending reductions of any non-defense spending program in the federal budget, roughly one-sixth of all such reductions.

Under the President's budget plan, Medicare outlays would be cut $5.1 billion below the Congressional Budget Office baseline in FY 88. Total five year savings would be $52.7 billion.

The new 1984 CBO data on hospital operating margins under the PPS program raises serious questions, not about the concept of PPS, but rather about the possibility of marginal adjustments to the DRGs which could provide a "painless" way of reducing Medicare outlays.

The CBO data will show that hospital margins are higher than anticipated. But the data also raises serious policy questions:

What will the margins be if trended out to 1987 and 1988, assuming no changes in the current PPS base?

If the margins are too high, what should the margins be?

How can we best reduce the margins to whatever is determined to be a "reasonable" level?

What should this Subcommittee recommend be done with the savings from adjustments to the PPS base?

Does the CBO data show that there are big operating margin "winners" and "losers"? Who are they and where are they?

These questions will be of central concern as the Subcommittee and the House works to set fiscal policy in 1988 and beyond. I look forward to a lively hearing today.

Chairman STARK. We have three panels this morning. While I have generally asked witnesses to summarize their written testimony in a short period of time and include their full written testimony in the record, I am going to just ask the witnesses today to forbear at least from reading prepared testimony but take as much time as they would like to summarize or highlight, particularly if we get into technical data, and I just ask them to understand, in the interest of those witnesses who made the second and third cut, that they probably, too, have other appointments today. And so if you can proceed to provide us the information in your testimony in the most expeditious manner, I am sure the committee would appreciate it.

The first panel is comprised of Dr. Nancy Gordon, the Assistant Director of Human Resources and Community Development from the Congressional Budget Office; Dr. Stuart Altman, the Chairman of the Prospective Payment Assessment Commission, ProPAC as we know it; and Larry Simmons, the Deputy Assistant Inspector General for Auditing, U.S. Department of Health and Human Services, who is accompanied by George Reeb, the Director of HCFA audits in HHS.

If you will proceed in the order in which I recognized you to present your testimony, we will have questions at the completion of the panel's testimony.

Dr. Gordon?

## STATEMENT OF NANCY M. GORDON, ASSISTANT DIRECTOR FOR HUMAN RESOURCES AND COMMUNITY DEVELOPMENT, CONGRESSIONAL BUDGET OFFICE

Ms. GORDON. I suggest that we start with table 1 on page 7 of my prepared statement, which shows hospitals' operating margins on their PPS payments.

Chairman STARK. May I withhold just a minute? Are copies of your testimony available at the press table? Were they earlier?

Ms. GORDON. I believe so.

Chairman STARK. All right. I hope the audience will not all jump up to grab them, but you might want to share with your neighbors out there. I am sure that there are other people in the room interested in your testimony.

Go ahead.

Ms. GORDON. Table 1 shows hospitals' operating margins on PPS payments for Federal fiscal year 1984. As you can see from the table, the average operating margin was 12 percent, and the larg-

est single contributing factor was cost reductions, which accounted for 5.5 percent. Case mix increases not accompanied by cost increases contributed another 2.5 percentage points.

Chairman STARK. What is a case mix increase?

Ms. GORDON. Let me start with a case mix, which is a number that reflects how complicated a hospital's set of patients are. That is based on the——

Chairman STARK. The higher the number, the more complex?

Ms. GORDON. Yes, and it is based on the weights that are used for the diagnosis-related groups, the DRG's.

Using unaudited data from 1981, when the 1984 payment levels were set, contributed another 1 percent to hospitals' operating margins, and all other factors combined accounted for the remaining 3 percent.

If we turn to figure 1 on page 10 of the statement, we see that there was considerable variability for different groups of hospitals around the average margin of 12 percent. Urban hospitals had a margin of 13.1 percent compared with rural hospitals at 6.6 percent. Similarly, when we compare teaching with nonteaching hospitals, we find that teaching hospitals were much higher.

If we turn to table 2 on page 13, we can see some illustrative projections of hospitals' operating margins on their PPS payments for 1985 through 1987. These illustrations are based on various assumptions about the behavior of hospitals' costs and their average case mix.

As you can see in the column for 1985, the average margin would rise from 12 percent to about 18 to 19 percent using this range of assumptions. It would then generally drift down in 1986 and 1987, possibly to as low as 13 percent, as shown in the top panel of that table.

I would like to concentrate the remainder of my time on the implications of these estimates, which are described starting on page 14 of the prepared statement.

Chairman STARK. If you can withhold just a moment, I find myself in the embarrassing position of not having page 14. [Laughter.]

Thank you.

Ms. GORDON. I hope that is not true of all of them.

Chairman STARK. No. I now have it.

Ms. GORDON. One of the most important implications, which actually starts at the beginning of page 15, concerns Federal expenditures, because these margins suggest that PPS payments could be reduced compared with continuing current policies.

In fact, it is generally agreed that the payment rate should be adjusted to reflect several factors that have contributed to increases in the operating margins of hospitals. First, the increment in payments from increases in the measured case mix that were not accompanied by increases in costs should be removed. Second, any site-shifting that lowered hospital costs should lead to lower PPS outlays.

Chairman STARK. Can I interrupt?

Ms. GORDON. Yes, of course.

Chairman STARK. If the panel will—please let me ask anybody else who wants to interrupt as we go along here. What you are

saying, in the increments in payments from the case mix that were not accompanied by costs, what you are really saying is that just by changing the numbers or how you rank a certain operation or procedure got you more money but it really did not cost you any more. Is that in effect what you are saying?

Ms. GORDON. Yes, that is exactly the point, although I would like to add that a good part of these changes in coding patients into higher valued DRG's resulted from hospitals having all sorts of incentives to code more accurately. We are not saying that this was somehow cheating the Government, only that, when the DRG system was first put into place, the classification of patients did not affect hospitals' payments from Medicare, and so the incentives to code precisely were not as strong as after the PPS system came into effect.

Chairman STARK. All right.

Ms. GORDON. Second, any site-shifting that lowered hospitals' costs should lead to lower PPS payments regardless of how payments for the services delivered in other sites are split among Medicare, the beneficiaries, and their families.

Finally, forecasting errors—for example, of the inflation in prices paid by hospitals—that led to incorrect rates being set should be corrected in subsequent periods.

A much more fundamental issue is how the gains from greater efficiency should be divided between the hospitals and the Federal Government, the latter operating on behalf of taxpayers and beneficiaries. The hospital industry argues that it should keep most or all of the gains as a reward for increased efficiency. In their view, this portion of the current operating margins is largely the complement of the risk of losses if costs were not controlled.

On the other hand, because the initial PPS rates were based on average costs and reflected the inefficiencies that had been fostered under retrospective cost reimbursement, others argue that taxpayers or beneficiaries should receive most of the gains from increased efficiency.

While there is general agreement that incentives for hospitals to achieve greater efficiency should be maintained, the implications of this view for dividing the gains between hospitals and the Federal Government are sharply debated. Industry representatives contend that if hospitals were not allowed to retain most or all of the gains, they would lose their incentives to be efficient.

Others point out, however, that from 1984 to 1987, lags in the availability of data meant that payment rates remained above the levels at which it now appears that care can be delivered efficiently. Since these lags could at best be shortened, hospitals would permanently retain part of the gains from efficiency even if the PPS rates were always cut to absorb all of the efficiency gains as soon as the data were available to measure them.

A third argument concerns the fact that the PPS, despite its complexity, still falls short of adjusting for all legitimate sources of variation in hospitals' costs. Therefore, some hospitals may have high PPS margins, while others have much smaller or negative ones, even though they are equally efficient.

In response, industry representatives argue that aggregate operating margins should remain high as a cushion for hospitals that

might otherwise be adversely affected by deficiencies in the PPS rates. They emphasize that the adverse consequences that might result from these deficiencies—such as lower quality care or reduced access—are more likely to occur if average operating margins are substantially reduced.

Opponents of this viewpoint acknowledge the imperfections in the present rates but want to focus effort on improving the measurement of legitimate differences in costs. They point out that inflating the margins of all hospitals also benefits those that are gaining from the deficiencies in the current system, so they believe that, at most, a small cushion should be provided as a temporary measure.

Yet another factor to consider is that, overall, the health care system is changing rapidly, with the potential for some undesirable outcomes. For example, many in the Congress are concerned about the provision of uncompensated hospital care for the medically indigent.

Although it has always been Medicare's tradition to pay only for Medicare patients, some of the current operating margins on PPS payments may be cross-subsidizing uncompensated care. In this case, if the Congress decides to restrain PPS payments, it may want to consider new initiatives for uncompensated care at the same time.

Perhaps the clearest implication is that having data available more rapidly would reduce the lags between setting the rates and evaluating their accuracy. The principles of the PPS system could be implemented more accurately if the 4-year lag in data were shortened.

That concludes my statement, Mr. Chairman.

[Statement of Ms. Gordon follows:]

STATEMENT OF NANCY M. GORDON, ASSISTANT DIRECTOR FOR HUMAN RESOURCES AND COMMUNITY DEVELOPMENT, CONGRESSIONAL BUDGET OFFICE

There has been considerable interest lately in the claim that hospitals are making substantial, and partially undeserved, "profits" under Medicare's prospective payment system (PPS). This was not an issue previously, when Medicare paid hospitals only for the costs they incurred in treating beneficiaries. Now, however, profits and losses are possible, because hospitals receive fixed payments for each patient that may exceed or fall short of their costs.

Following a brief description of the PPS, my testimony will address three aspects of this issue: The Congressional Budget Office's (CBO's) preliminary estimates of operating margins on Medicare's PPS payments in 1984, as well as their sources and their distribution; projections of these operating margins for 1985 through 1987; and the implications of these findings for possible changes to the PPS.

BACKGROUND

In passing the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Congress laid the groundwork for the PPS, which was enacted as part of the Social Security Amendments of 1983. Both actions were prompted by an unacceptably high growth rate in Medicare's outlays for hospital costs, which averaged 18 percent a year between 1975 and 1982, or 8 percent a year above general price inflation. Moreover, concern was widespread that the previous cost-based reimbursement system did not encourage the efficient provision of care, and that it was not improving beneficiaries' health in relation to federal spending. In particular, cost reimbursement encouraged hospitals to provide all services that had any benefit at all—not just those that were worth more than they cost.

The main objectives of the PPS are to lower the growth rate of Medicare's payments to hospitals and encourage efficiency in the provision of hospital care, while

not adversely affecting its quality. It attempts to do so by specifying payment rates in advance and requiring hospitals to bear the loss if their costs are higher. In exchange, hospitals are allowed to keep the difference if their costs are lower than the payments. Thus, hospitals face strong financial incentives to provide care as efficiently as possible. Peer review organizations monitor the quality of care.

In principle, the fully implemented PPS promises to pay hospitals an amount for each patient, or case, equal to the cost of treatment in an efficiently run hospital.[1] Because costs vary among equally efficient hospitals for several legitimate reasons, the system also includes numerous adjustments according to various characteristics of hospitals. As a result, Medicare's payments for the same type of case differ considerably among hospitals.

Specifically, the PPS sets fixed payment rates in advance for each of 471 categories known as diagnosis-related groups (DRGs) that were designed to reflect the value of resources used to treat different types of conditions. During a four-year transition, the prospective amounts have been based on a combination of hospital-specific, regional, and national PPS rates, with the hospital-specific portion reflecting each hospital's own pre-PPS costs.[2] Starting with hospital's fiscal years that begin in federal fiscal year 1988, however, payments will be based on national rates only. These rates will continue to be calculated separately for urban and rural areas and adjusted for differences in wage levels among geographic areas, for the size of an institution's in-hospital training program for physicians, and if a disproportionately large share of the hospital's patients have low incomes.

The national rates are based on the average cost per case in 1981, inflated to represent later years.[3] Unfortunately, these data reflect the inefficiencies that had developed under the previous retrospective cost reimbursement system.

A process for updating the payment rates in subsequent years was also established. For 1985, Medicare's PPS rates were increased by the amount estimated to result in the same payments to the hospital industry as a whole as would have occurred under TEFRA.[4] For fiscal year 1986 and beyond, however, the Secretary of Health and Human Services (HHS) was given discretion over the percentage change in the payment rates—often referred to as the "update factor." In addition, an independent Commission—the Prospective Payment Assessement Commission (ProPAC)—was established to make recommendations about the PPS, including each year's update factor, that the Secretary is to consider in making final decisions.

The methodologies established by both the Administration and ProPAC to determine their update factors for 1986 and beyond have two basic components. One is a measure of change in the prices of goods and services purchased by hospitals—often called the hospital's market basket. The second is a composite factor (called the discretionary adjustment factor by ProPAC), which is based on changes in technology, productivity, and cost effectiveness, as well as on forecasting errors in the payment rates for previous years. While the inflation or market-basket portion of the update factor is generally expected to be positive, the composite factor can be either positive or negative. In addition, the Administration and ProPAC recommended different ways to adjust the 1986 and 1987 payment rates to reflect improved coding of patients into DRGs by physicians and hospitals. In the end, the Congress enacted a 0.5 percent increase for 1986 and a 1.15 percent increase for 1987.

### OPERATING MARGINS ON HOSPITALS' PPS PAYMENTS IN 1984

Hospitals' 1984 operating margins, defined as: [revenues minus costs divided by revenues], were determined by several factors.[5] Because aggregate PPS payments

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[1] Some costs and some institutions are exempt from the PPS. Capital-related costs, such as depreciation and interest payments, and the direct costs of graduate medical education programs continue to be reimbursed separately. Moreover, children's hospitals, rehabilitation centers, and psychiatric hospitals are exempt from the PPS.

[2] The last year of transition will begin for all participating hospitals during federal fiscal year 1987. In this year, 75 percent of each hospital's payment is based on a combination of regional and national rates, while the remainder is based on its hospital-specific rate.

[3] The same data, which had not been audited, were used to set the regional rates. Audited data on hospital costs in 1982–1983 were used to set the hospital-specific amounts.

[4] Total PPS payments for 1984 were also supposed to match the outlays that would have occurred under TEFRA. TEFRA limited the growth of hospital reimbursement per admission for 1983, 1984, and 1985 to the rise in prices for the goods and services hospitals purchase as inputs, plus one percentage point for other factors such as cost-increasing advances in technology.

[5] A hospital's margin is not the same as its profit rate, which is the difference between revenues and costs divided by costs. For example, a margin of 10 percent is equivalent to a profit of 11.1 percent, while a margin of 15 percent is equivalent to a profit of 17.6 percent.

were intended to match the outlays that would have occurred under TEFRA, they were expected to be lower than the operating costs that hospitals as a group were experiencing when the system first went into effect. On the other hand, policymakers hoped that hospitals would respond to the new incentives, as least by enough to lower aggregate costs to the TEFRA limits, and possibly by more. In the former case, the average operating margin would have been zero; in the latter case, it would have been positive.

Based on recently available data, CBO estimates that the average operating margin on Medicare's PPS payments during federal fiscal year 1984 was actually 12.0 percent.[6] In other words, on average, the cost of treating each Medicare case was 88 percent of the PPS payment.

Some hospitals have also been affected, however, by a decline in the number of Medicare beneficiaries they are testing. Although the average drop in admissions between 1983 and 1984 was 1.6 percent, larger reductions for some hospitals may have noticeably offset their operating margins per case.

*Factors contributing to hospitals' PPS operating margins*

The most important factor contributing to hospitals' operating margins on PPS payments in 1984 was the decrease in their costs relative to what was expected when the system was designed (see Table 1). Hospitals' actual costs were about 10 percent lower than the projections on which the national and regional payment rates were based, and 6 percent lower than the projections on which the hospital-specific rates were based.[7] Some of these cost reductions almost certainly came from increased efficiency that is, providing the same quality of care using fewer resources or lower priced resources—as envisaged by the system's designers. In addition, certain costs that were included in setting the payment rates may have been shifted to outpatient settings. For example, some laboratory tests and x-rays that previously occurred after admission may now take place beforehand. Such "site-shifting" activities would mean, in effect, that double payment is occurring. Medicare would be continuing its inpatient reimbursement for services actually performed outside of that setting, even though these services were also paid for separately by some combination of Medicare, the patients, and their families. Finally, beneficiaries may have received a lower quality of care. Unfortunately, it is not yet possible to estimate the extent to which these three factors contributed to the overall reduction in costs, and a final determination may never be possible.

TABLE 1.—HOSPITALS' OPERATING MARGINS ON PPS PAYMENTS BY SOURCE, FISCAL YEAR 1984 [1]

| Source | In percent per case | In dollars per case |
|---|---|---|
| Cost reductions [2] | 5.5 | 190 |
| 1981–1984 case mix increases not accompanied by cost increases [3] | 2.5 | 85 |
| Use of unaudited 1981 cost data in setting 1984 payments [4] | 1.0 | 35 |
| All other factors [5] | 3.0 | 105 |
| Total | 12.0 | 415 |

[1] Operating margin is defined as payment per case, minus cost per case, divided by payment per case.

[2] Difference between 1981 costs per case projected to 1984, which served as the basis for setting the national and regional rates, and 1984 actual cost per case.

[3] Effect on margins of the difference between 1984 case mix and 1981 case mix after accounting for any contributions of higher case mix to actual 1984 costs.

[4] According to estimates by the General Accounting Office, and CBO, the regional rates for 1984 would have been 3 percent to 5 percent lower, if audited data had been used.

[5] Other factors include errors in forecasting, the increase in the cost of the market basket, as well as interactions among the factors shown separately above.

Source: Congressional Budget Office.

Another 2.5 percent of the 1984 operating margins is attributable to the rise in the average "case mix" of hospitals that occurred because patients were placed in DRGs with higher payment rates, on average, than had occurred before.[8] About

[6] Maryland, Massachusetts, New Jersey, and New York hospitals are omitted from these calculations, because they were exempted from the PPS by waiver in 1984. The average margin is calculated by weighting hospitals according to their PPS payments.

[7] The average 1984 cost per case for hospitals in the PPS system was expected to be $3,360 based on the 1981 data and $3,200 based on the 1982–1983 data. It was actually only $3,025.

[8] A hospital's "case mix" is a number that reflects the resource intensity of its patients. It is based on the distribution of the hospital's patients among the various DRGs.

three-quarters of this increase in the average case mix came about because hospitals had much stronger incentives to code patients accurately than when the DRG classification did not affect their receipts from Medicare. Because hospitals did not incur any greater costs than they had previously, however, their operating margins rose. In contrast, about one-fourth of the increase in the average case mix resulted from other factors, such as some less costly procedures being shifted to outpatient setting.[9] Because this portion was accompanied by an increase in hospitals' average costs, it did not contribute to their operating margins.

Another 1 percent of the operating margins is the result of the 1984 regional PPS rates being based on hospitals' costs from unaudited 1981 reports, which subsequent analyses reveal were too high.[10] The remaining 3.0 percent of hospitals' operating margins stems from a variety of factors, including forecasts of inflation in the cost of the hospitals' market basket that were higher than actually occurred.

*Differences in margins for groups of hospitals*

While the average operating margin on PPS payments is 12 percent, the values for certain groups of hospitals differed considerably. Urban hospitals—which represent about 50 percent of hospitals, but account for over 80 percent of PPS payments—had an average operating margin of 13.1 percent. In sharp contrasts, the average margin for rural hospitals was 6.6 percent, or about one-half that of urban hospitals (see Figure 1). In addition, the operating margins of teaching hospitals were noticeably higher than those of nonteaching hospitals—15.4 percent for major teaching hospitals and 13.8 percent for minor teaching hospitals, compared with 10.2 percent for nonteaching ones.[11]

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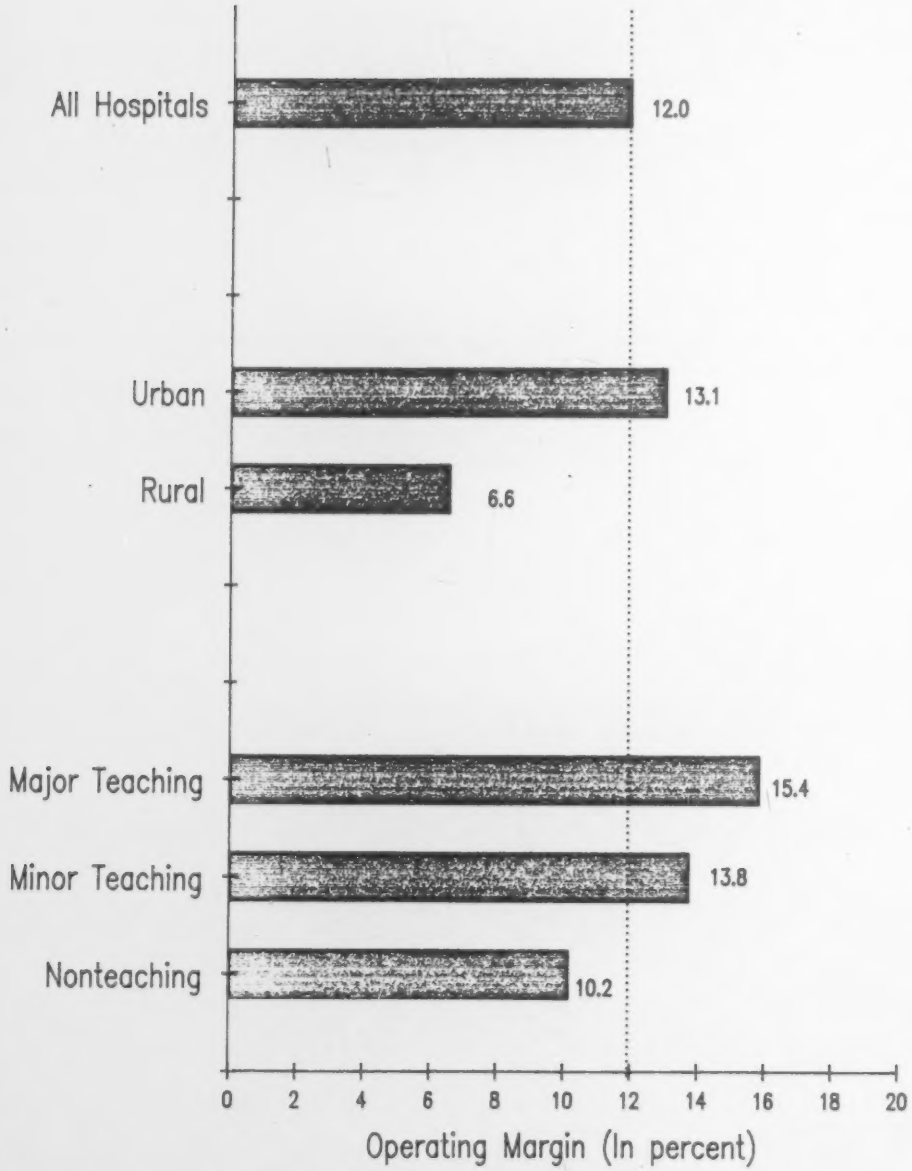
[9] Another possible factor is the aging of Medicare beneficiaries.

[10] The General Accounting Office found they were about 3 percent too high. See "Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates," Report to Congress, July 18, 1985. In addition CBO estimates that, if the audited 1982-1983 data had been used instead, the regional rates would have been 4 percent to 5 percent lower.

[11] Differences in operating margins would also be observed for hospitals with varying numbers of beds or located in different census divisions. These differences are explained by the varying proportions of urban hospitals and teaching hospitals in these groups—not by the size of the hospital or its region. Major teaching hospitals are defined as those with 25 or more interns and residents for each 100 beds; minor teaching hospitals have smaller programs.

## Figure 1. Hospitals' Operating Margins on PPS Payments by Selected Characteristics, 1984




Source: Preliminary Congressional Budget Office estimates.

The considerable variation in operating margins between urban and rural, and teaching and nonteaching, hospitals results from the same factors that explain the average margin. For example, costs of urban hospitals dropped by 6.2 percent, while costs for rural hospitals were only 3.8 percent lower. In addition, the average case mix of major urban hospitals rose by 7.9 percent, compared with 5.4 percent for rural hospitals. Finally, although only 25 percent of the 1984 payment was affected by the indirect teaching adjustment, it was deliberately set above the level estimated to account for teaching hospitals' extra operating costs for patient care.[12]

### PROJECTED OPERATING MARGINS ON PPS PAYMENTS, 1985–87

Although it is not yet possible to estimate accurately the operating margins of hospitals on PPS payments after 1984. CBO has prepared some illustrative projections of these margins under several assumptions about the behavior of payments and costs.

Most factors that determine PPS payments are specified in advance by legislation or regulation; some uncertainty in these projections remains, however, because changes in hospitals' average case mix are known only after their bills are filed.[13] Consequently, CBO's projections consider two alternatives: All changes in the average case mix of hospitals after 1985 were accompanied by matching cost increases; and over and above this type of change, the average case mix rose 1.5 percent for 1986 and 1.0 percent for 1987.

There is considerably more uncertainty about how hospitals' costs have changed, since they are subject to many forces such as changes in input prices, greater efficiencies in operation, adoption of new technologies, and changes in the overall level of admissions.[14] As a result, the projections are based on the same increases in the cost of the hospitals' market basket, but consider four different assumptions about the degree to which the cost reductions for the first year of PPS were reversed or continued: Declining admissions and changes in technology together accounted for an annual increase in costs of 1 percentage point for 1985 through 1987; all factors other than the change in the cost of the market basket exactly offset one another each year; overall costs after 1984 rose at the rate of increase in the cost of the market basket minus 2.5 percentage points for 1985, minus 1.0 percentage point for 1986, and minus 1 percentage point for 1987; and additional efficiencies were achieved that approximately equaled those achieved by 1984—specifically, overall costs grew by the increase in the cost of the market basket minus 4 percent for 1985, minus 2 percent for 1986, and minus 1 percent for 1987.

Table 2 shows the operating margins that would occur under combinations of the assumptions about the average case mix and hospitals' costs.[15] The projected rise in margins for 1985—to between 17.6 percent and 19.4 percent—also results from the larger proportion of payments that was based on the regional and national rates and from some errors in forecasting inflation. For 1986 and beyond, the projected margins generally move downward slightly. This decline takes place because legislated updates in payments were below the change in the cost of the market basket by 2.6 percentage points in 1986 and 2.4 percentage points in 1987, and because of the assumptions about hospitals' cost and their average case mix. The range of uncertainty about the cumulative effects of these forces widens the ban of possible margins for the later years.

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[12] See statement of Rudolph G. Penner, Director, Congressional Budget Office before the Task Force on Health, Committee on the Budget, U.S. House of Representatives, September 30, 1985.

[13] In 1985, the average case mix rose by 5.1 percent. Cost increases are estimated to have accompanied about 2.5 percentage points of this change.

[14] The recent decline in admissions may contribute to rising costs per case, as fixed costs are spread over fewer patients. Total admissions are estimated to have fallen by 5.1 percent in 1985 and by 2.5 percent in 1986.

[15] The estimates exclude Massachusetts and New York because of a lack of data, even though they entered the PPS in 1986. Maryland and New Jersey are also excluded because they remain exempt from the PPS by waiver.

TABLE 2.—ILLUSTRATIVE PROJECTIONS OF HOSPITALS' OPERATING MARGINS ON PPS PAYMENTS PER CASE, 1985–1987

| | Federal fiscal year— | | |
|---|---|---|---|
| | 1985 | 1986 | 1987 |
| Post-1984 costs reflect changing input prices and small net cost increases: | | | |
| Case mix increases in 1985, constant thereafter | 17.6 | 15.7 | 12.8 |
| Case mix increases through 1987 | 17.6 | 17.2 | 13.8 |
| Post-1984 costs reflect changing input prices and no net cost reductions: | | | |
| Case mix increases in 1985, constant thereafter | 17.6 | 16.6 | 14.5 |
| Case mix increases through 1987 | 17.6 | 18.1 | 15.5 |
| Post-1984 costs reflect changing input prices and some net cost reductions: | | | |
| Case mix increases in 1985, constant thereafter | 18.8 | 18.5 | 17.3 |
| Case mix increases through 1987 | 18.8 | 20.0 | 18.3 |
| Post-1984 costs reflect changing input prices and larger net cost reductions: | | | |
| Case mix increases in 1985, constant thereafter | 19.4 | 19.9 | 18.8 |
| Case mix increases through 1987 | 19.4 | 21.4 | 19.8 |

Source: Congressional Budget Office.

Operating margins for 1988 would be 2 percent lower than the illustrations for 1987, if the only additional factor affecting them were the legislated increase in payment rates that is set at 2 percent less than the rise in the cost of the market basket. But other factors such as higher or lower costs would also affect the margins. Moreover, their pattern will not be the same in 1988 as is shown in Figure 1 for 1984 for various types of hospitals. One reason is that payments will be based entirely on national rates, so they will be redistributed among hospitals with different characteristics. In addition, little is known about the distribution of cost changes among types of hospitals.

### IMPLICATIONS FOR CHANGES TO THE PPS

The substantial operating margins on Medicare's payments to hospitals—in 1984 and most likely in subsequent years as well—have some generally acknowledged implications, but they raise other issues for the design of the PPS over which there is considerable disagreement.

One of the most important implications concerns federal expenditures, because these margins suggest that PPS payments could be reduced compared with continuing current policies. In fact, it is generally agreed that the payment rates should be adjusted to reflect several factors that have contributed to increases in the operating margins of hospitals. First, the increment in payments from increases in the measured case mix that were not accompanied by additional costs should be removed. Second, any site-shifting that lowered hospitals' costs should lead to lower PPS outlays, regardless of how payments for the services delivered in other sites are split among Medicare, the beneficiaries, and their families. Finally, forecasting errors that led to incorrect rates being set should be corrected in subsequent periods. (Although both ProPAC and the Secretary of HHS followed these principles in determining the update factors for 1986 and 1987, the downward adjustments actually made to the PPS rates were smaller than recent data suggest were warranted.)

A much more fundamental issue is how the gains from greater efficiency should be divided between the hospitals and the federal government, the latter operating on behalf of taxpayers and beneficiaries. The hospital industry argues that it should keep most or all of these gains as a reward for its increased efficiency. In their view, this portion of the current operating margins is largely the complement of the risk of losses if costs were not controlled. On the other hand, because the initial PPS rates were based on average costs and reflected the inefficiencies that had been fostered under retrospective cost reimbursement, others argue that taxpayers or beneficiaries should receive most of the gains from increased efficiency.

While there is general agreement that incentives for hospitals to achieve greater efficiency should be maintained, the implications of this view for dividing the gains from efficiency are also sharply debated. Industry representatives contend that if hospitals were not allowed to retain most or all of the gains, they would loose their incentives to be efficient. Others point out, however, that from 1984 through 1987 lags in the availability of data meant that payment rates remained above the levels at which it now appears that care can be delivered efficiently. Since these lags

could, at best, be shortened, hospitals would permanently retain part of the gains from efficiency, even if the PPS rates were always cut to absorb all of them as soon as the data were available to measure them.

A third argument concerns the fact that the PPS system, despite its complexity, still falls short of adjusting for all legitimate sources of variation in hospitals' costs. For example, it appears that the wage index does not adequately reflect differences among localities and that the DRG classification does not fully account for severity of illness and, hence, for the costliness of different types of patients. Therefore, some hospitals may have high PPS margins, while others have much smaller or negative ones, even though they are equally efficient.

In response, industry representatives argue that aggregate operating margins should remain high as a "cushion" for hospitals that might otherwise be adversely affected by deficiencies in the PPS rates. They emphasize that the adverse consequences that might result from these deficiencies—such as lower quality of care or reduced access for some beneficiaries—are more likely to occur if the average operating margin is substantially reduced. Opponents of this viewpoint acknowledge the imperfections in the present rates, but want to focus effort on improving the measurement of legitimate differences in costs. They point out that inflating the margins of all hospitals also benefits those that are gaining from the current deficiencies in the system, so they believe that at most a small "cushion" should be provided as a temporary measure.

Yet another factor to consider is that the overall health care system is changing rapidly, with the potential for some undesirable outcomes. For example, many in the Congress are concerned about the provision of uncompensated hospital care for the medically indigent. Although it has always been Medicare's tradition to pay only for Medicare patients, some of the current operating margins on PPS payments may be cross-subsidizing uncompensated care. In this case, if the Congress decides to restrain PPS payments, it may want to consider new initiatives for uncompensated care at the same time.

Perhaps the clearest implication is that having data available more rapidly would reduce the lags between setting the rates and evaluating their accuracy. Information about 1984 is now being used in setting the 1988 payment rates. Such lags have led both to higher payments, on average, than intended and to variations in payments for different types of hospitals that appear not to be related to differences in efficiency. The principles of the PPS system could be implemented more accurately, if the four-year lag in data were shortened.

Chairman STARK. Thank you very much, Dr. Gordon.

Stu?

**STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, ACCOMPANIED BY HAROLD A. COHEN, CHAIRMAN, SUBCOMMITTEE ON HOSPITAL PRODUCTIVITY AND COST EFFECTIVENESS, AND EXECUTIVE DIRECTOR, MARYLAND HEALTH SERVICES COST REVIEW COMMISSION**

Mr. ALTMAN. Thank you, Mr. Chairman. It is a pleasure to be here this morning.

I would like to introduce my colleague, Dr. Hal Cohen, who is the chairman of our subcommittee that deals with productivity.

As you know, Mr. Chairman, ProPAC was set up in 1983 to try to provide the Congress and the administration with assistance. We try as best we can to look at all sides of the issues. We appreciate what Mr. Gradison said about concern that we not look only backwards but primarily forward.

I am here this morning to tell you primarily of what our staff has found with respect to these margins. They have just become available to the Commission. The Commission itself has not voted on them. We did discuss them in our last meeting anticipating this hearing, so some of what I will be talking about are my own opin-

ions, and I will try to put my hand up to indicate that it may not be shared by my fellow commissioners. [Laughter.]

Hal is here as a watchdog to make sure that I am——

Chairman STARK. Sort of like the statue of Lenin.

Mr. ALTMAN. That is exactly right. [Laughter.]

Sometimes the hand will not go up as high as it probably ought to.

By and large, our staff supports the general assessment of the CBO with respect to these margins. Actually, the margins we came up with for the first year of PPS—and the differences between what costs were anticipated in 1981 and what they actually were—was closer to 15 percent, actually 14.8 percent. But, as Dr. Gordon indicated—and I will several times—we do need to be careful and cautious about what these numbers mean and how we use them.

First of all, there are significant distributional effects and aspects of payments levels under PPS. We have gone into detail—and it appears in our complete testimony—looking at hospitals by decile, and you will see, when you look at those numbers, that you will have a substantial number of hospitals who are on the low side of the margins actually, with numbers closer to minus 10 percent. This is the next-to-the-last page of the testimony, table 1.

So 10 percent of the hospitals had PPS margins of less than 5 percent. On the other side, there were 10 percent of the hospitals which had margins which exceeded 23 percent. And so one needs to be concerned about these differences when we start talking about taking margins away. In addition, there are several other factors that must be taken into account. When PPS was set up there was a set of incentives for hospitals to become more efficient, and it is appropriate, therefore, that the costs are lower than anticipated. I think everyone should take credit for that, most importantly the hospitals. They did part, if not all, of what was expected of them.

However, it is also clear that, when you look at these numbers, the margins are in excess of what can be given in terms of simple credit for efficiency. They just are.

Now, I want to emphasize in the beginning, what we are talking about, and I think what the CBO was talking about, is not going back and taking away from hospitals that which has already been paid. The question before you and before all of us is how do we move forward. Do we continue to include these costs in the base for future payments? So when we talk about there is 12 percent taken away, we are not talking about taking it away, and if I lapse into that jargon, it is incorrect and I should be slapped. [Laughter.]

Chairman STARK. Do you guys want to flip for the honor? [Laughter.]

Mr. ALTMAN. Well, we all do it, and it is not right, and it is easy to say.

Now, as Dr. Gordon indicated, there are significant differences when you look across the types of hospitals. Major teaching hospitals showing the greatest margins, over 21 percent, and rural hospitals, particularly small rural hospitals, showing the lowest margins, where the numbers are closer to 5 to 6 percent. Now, again, that should caution us to be concerned about taking it away in some kind of simple way.

Also, we need to make a distinction between a hospital's PPS margins and its total margins. The PPS margins are the amount that hospitals receive in excess of the cost of treating Medicare patients.

Now, there are two other relevant sets of numbers that we present in table 2. Total margins are those which take account of all costs and revenues for a hospitals' business. Finally, patient margins focus on the hospital's patient operating costs and revenues.

The dramatic differences can be seen. The average PPS margins were 11.6; the average total margins were 6.7; and the average patient margins were 2.5. Therefore, we do need to take account of that. Nevertheless, I think it is appropriate that Congress focus on what it pays for Medicare patients so that we should try to get those numbers in line with what is a reasonable amount.

I think we should try not to underpay because we don't want a lot of cost-shifting going on; nor should we be in the business, I think, of paying more than our share. So, it is that balancing act we are here to talk about.

As we have moved through the last 3 or 4 years, it has become clear that the hospital industry is financially healthy, and I think we ought to feel positively about that. That is nothing to feel negative about. There is nothing to blame anybody about. But, by and large, the industry is healthy, and for those of us who look to it occasionally for our health care, we want that to happen.

Now, it is also true, however, that the long-term effects of PPS, as Mr. Gradison indicated, require a system in which patients, hospitals, and the Government feel good about each other. It does seem to us that it is important that we develop a fair set of expectations for everybody. As I begin to give you my ideas of what should happen, I hope they will be taken in that context.

Now, since the beginning of PPS, you have asked us at ProPAC to make recommendations to you on what the update factor should be. In other words, how much should the DRG rates be increased each year? We have tried to follow the law in terms of looking at the market basket and then making certain critical adjustments, and we have tried to make appropriate adjustments both up and down.

We believe that hospitals should receive more money for certain technological advances. On the other hand, we do not feel it is appropriate that they receive money, extra money, where there has been a substitution, or movement of patient's cost to the outpatient setting where Medicare part B is paying for services.

We also do not feel it is appropriate for hospitals to receive extra payment for coding changes which did not result from increases in the complexity of the patients diagnosis and care.

On the positive side, we have been at odds with the administration when we found that hospitals were not given credit for treating sicker patients. Every indication we have is that, as you reduce admissions and length of stay, the average patient treated in a hospital in 1987 is sicker than he was in 1983.

And so we have made our recommendations to you, and you have listened—and we appreciate that—and made your own recommendations. And when you get through with that balancing act, hospi-

tals have received update amounts which have been less than the market basket inflation rate. However, when you look at the total payments hospitals have been receiving, these payments are significantly higher than increases Congress has mandated in the update factor.

All right. We have found a 12-percent discrepancy between actual and projected first year PPS costs. This discrepancy, along with the margins, leads to consideration of numbers that make sense for thinking about adjustments in the future? Here again, I am not speaking on behalf of ProPAC—the Commission has not voted. I can just give you the thinking of the Commission as it has moved along in its deliberations. That thinking is that the 12 percent needs to be adjusted downward to take into account past reductions for productivity.

We knew rates were high. We did not know how high they were, but every indication, as we went around the country, indicated that payments were flowing in at levels in excess of what was expected. So, over the last 3 or 4 years, we have already been nibbling at the pie, and it would be inappropriate to ask for the hospitals to accept the full 12 percent reduction.

That is, part of it, I believe, Mr. Chairman, is appropriate for hospitals to receive, part of the benefits of this productivity increase, or we are not going to see hospitals continue their productivity increases.

Now this question is a judgment call. There is no scientific model that I can give you that says you should give them so much. Hospitals might come here and say they deserve it all. If I were in their shoes, I would probably say the same thing.

I could make an equally good case that says, in a tough competitive marketplace, hospitals should wind up with none of it. Ask the farmers in this country. They would like nothing more than to have their prices high and their production high, and that cruel market has been taking it all away from them.

But, given the fact that there is no magic formula, we say, Suppose we share it? Suppose there was a sharing of 50–50 between what the hospitals get and what the Government and the beneficiaries get? If you take that away and share it, plus you recognize this business of coding increases and site substitution, you begin to get down closer to numbers which are in the 4.5 to 5 percent range.

There is one other kicker here that I need to mention. Two years ago we were analyzing the distributional effects of movement to national PPS rates. You had asked us, your staff had asked us, to do this. We were just doing it, and we found that, lo and behold, as we moved from hospital-specific and regional rates to national rates, the payments increased more than they were supposed to, and we found that there was a 4 percent extra payment rate built into the system as you moved to national rates. And we have reported that to you.

Now, that 4 percent, given the fact that each percent is $400 to $500 million, is a significant amount of money. My own view is that 6 percent or so can appropriately be taken out of the base for future payments. My own view also is that a reduction should not be taken out at one time, but perhaps what we should do is adjust

the standardized amount over a 3-year period, or a percent-and-a-half to 2 percent per year to bring the base in line for the future.

I would caution that we not just willy-nilly do it for everybody. I don't have a formula here to tell you how to do it, but I think if we do it for everybody, there are going to be hospitals that did not benefit from this gain that are going to get whacked with the loss, and some of them could go under. So I would be glad to have our staff and the Commission work with you, should you decide to do it, on how best to do it.

So that is where we are. It is a situation which I think will deserve careful consideration by the Commission and by the Congress, and we should be cautious in how we attempt to adjust it back.

But I would like to thank you, Mr. Chairman, for the opportunity of being here this morning and hope that we can answer some questions later.

[Statement of Mr. Altman follows:]

Statement of Stuart H. Altman, Ph.D., Chairman,
Prospective Payment Assessment Commission

Mr. Chairman, I appreciate your invitation to appear before the subcommittee to discuss the work of the Prospective Payment Assessment Commission. I am accompanied today by Harold A. Cohen, PhD., Chairman of ProPAC's Subcommittee on Hospital Productivity and Cost Effectiveness and Executive Director of Maryland's Health Services Cost Review Commission.

One of the most important ways PPS influences the health care system is to affect the financial status of hospitals. As part of our effort to assess the impact and functioning of PPS we have thus carefully reviewed hospital financial status. This is because we believe that the financial success or failure of hospitals can affect the access and quality of health care for Medicare beneficiaries. I am pleased to share with you today the information which we have developed on hospital operating margins, and to describe how we plan to use this and other information in updating the PPS payment amounts.

Prior to PPS, hospitals were paid on the basis of their costs as defined by the Medicare program. This method of payment resulted by definition in Medicare margins which were zero. One of the basic tenets of PPS was to provide hospitals with financial incentives to improve efficiency and productivity in the delivery of services. It was intended that hospitals be placed at financial risk and that they share in financial gains. Therefore, some level of profit or surplus was a desired goal of PPS.

PPS Margins from Medicare Cost Reports

ProPAC's analysis of hospital margins is based on information from the Medicare cost reports submitted for the first year of PPS and is comparable to analyses completed by other organizations. Our review of this data suggests that the first-year PPS margin for hospitals was 14.8 percent.

Our findings and those of others must be interpreted with caution, however. First, PPS margins do not reflect the overall financial condition of hospitals. A hospital could, for example, have a relatively high Medicare margin, but have considerable uncompensated care, which would lower its total margin and impair its financial status. Second, the data are from the first year of PPS. During fiscal year 1987, hospitals entered the fourth year of PPS. The transition to fully Federal rates, policy adjustments, and other changes since PPS implementation will affect hospital financial performance. For example, recent data on overall hospital margins show that total margins have declined from 6.7 percent in 1985 to 5.5 percent in 1986. In addition, the relative margins across groups of hospitals will be affected by policy changes, such as the lowering of the indirect teaching adjustment and changes in the calculation of the outlier payment pool.

Finally, cost report data are subject to various problems. Techniques used to allocate costs to hospital departments and apportion costs between inpatient Medicare, other Medicare, and non-Medicare patients may inaccurately assign costs. Because cost reports are no longer the basis for payment, recent cost report data may not be comparable to past data. We are told that some hospitals have not had the protracted and extensive negotiations with fiscal intermediary auditors over their cost reports which might have occurred at a time when those reports were used as the basis for payment. As a result of these factors, PPS margins based on cost reports could be over- or under-stated.

ProPAC has approached this analysis from the standpoint of distributional affects as well as the overall size of the PPS margins. We believe that although the level of margins is

important, examining the differences in margins across hospitals can provide information about possible systematic problems in PPS payments to hospitals.

Distributional Differences in Margins Across Hospitals

Data from the first-year PPS Medicare Cost Reports suggest that there are significant differences, some systematic, in how well hospitals were succeeding financially in the first year of PPS. Table 1, attached at the end of my statement, shows the distribution of first-year PPS margins by type of hospital. As I indicated, the average first-year PPS margin for hospitals was 14.8 percent. Despite this high average margin, 10 percent of hospitals had PPS margins less than -5.0 percent. Another 10 percent had margins greater than 23.4 percent. Costs and payments for capital and direct medical education, which are separate from PPS, are excluded from the margin calculations.

A number of factors are likely to contribute to the range of PPS margins. Some hospitals may have low margins because they experience unusually high Medicare costs that are not fully paid by the PPS system. Other hospitals may have been slower to reduce costs either prior to or during the first year of PPS. This may be particularly true of hospitals with relatively high volume declines, since the cost-cutting response to volume declines is not immediate. On the other hand, hospitals might have generated relatively high margins by being quick to reduce costs. In addition, payments to some hospitals were higher than expected because of the PPS payment formula. Growth in the Medicare case-mix index, for instance, was the source of significant payment increases in the early years of PPS.

Differences Between Urban and Rural Hospitals

Urban and rural hospitals showed the most striking systematic difference in first-year PPS margins. As a group, rural hospitals had a first-year PPS margin of less than 9 percent, compared with 16 percent for urban hospitals. Margins for one-quarter of rural hospitals were less than -0.2 percent. In contrast, the 25th percentile for urban hospitals was 7.8 percent. The group of rural hospitals with fewer than 50 beds had particularly low margins--10 percent of these hospitals had margins of -18.4 percent or less.

Changes in payment policy since the first year of PPS are likely to have somewhat reduced the disparity between the urban and rural groups. The contributions of rural hospitals to funding outlier payments have been reduced to reflect more appropriately the outlier experience of these hospitals. Moreover, beginning in fiscal year 1988, the method for calculating national payment rates will change. Under the new discharge-weighted method, payment rates for rural hospitals will be less influenced by the many small, low-cost rural hospitals with few Medicare discharges. Partly as a result of this policy change, small rural hospitals will experience relatively large increases in payment as a result of the transition to fully national PPS payment rates.

The large difference in margins between the urban and rural groups probably reflects more than PPS payment disparities, however. Bed size seems to be an important factor. First-year PPS margins for urban hospitals increase with bed size. As with rural hospitals, small urban hospitals were more likely to have negative margins than larger urban hospitals.

Margins in Major Teaching Hospitals

Major teaching hospitals had relatively high PPS margins -- 21.1 percent as a group, compared with 12.4 percent for nonteaching hospitals. The relatively generous indirect teaching allowance in the first year of PPS had some influence on these margins. This cannot be a full explanation, however, since in the first year of PPS the teaching allowance was applied to only the quarter of payments that were based on regional averages. The rest of the per-case payment rate was hospital-specific.

To some extent, differences in PPS margins across regions and by teaching and disproportionate share status were influenced by the low margins for small rural hospitals. For example, 10 percent of the hospitals in the Mountain Census Division, which has a relatively high proportion of small rural hospitals, had first-year PPS margins of -14.9 percent or less. The group of nondisproportionate share hospitals includes most rural hospitals, since less than 9 percent of rural hospitals qualify for disproportionate share status. The addition of disproportionate share payments in the third year of PPS would increase the disparity between these groups.

Both the level and distribution of current PPS margins may differ from those shown for the first year of PPS. Changes in costs and responses to PPS incentives are likely to have occurred since then. As mentioned previously, changes in payment policy have also affected the distribution of payments to hospitals. These include the transition to national rates, the reduction in additional payments to teaching hospitals, implementation of an adjustment to payments for hospitals serving a disproportionate share of low-income patients, and changes in payments to rural hospitals.

Comparison of PPS Margins with Total Margins and Patient Margins

PPS margins are not directly indicative of the overall financial condition of hospitals. Median first-year PPS margins were higher than median total and patient margins for the same reporting period (see the attached Table 2). Total margins are calculated by taking the difference between total revenue and total expenses as a percent of total revenue. Patient margins are the difference between net patient revenue and total operating expenses as a percent of net patient revenue. Unlike the PPS margins, total and patient margins reflect revenue and expenses for all payers, and include capital and direct medical education costs and revenues.

The median first-year PPS margin was 11.6 percent, compared with a 6.7 percent median total margin and a 2.5 percent median patient margin. By definition, half the hospitals have margins above the median and half below.

Overall margins were computed using financial information provided on the Medicare Cost Report from the first year of PPS. This section of the cost report is not audited and under PPS does not affect Medicare payment for inpatient hospital operating costs. The overall medians presented here, however, are consistent with data from the American Hospital Association for the relevant time period.

First-year PPS margins may be relatively high due to the structure of the PPS payment system. Financial incentives included in TEFRA and the change to prospective payment resulted in cost reductions in the care of Medicare patients. These cost reductions contributed substantially to the relatively high margins we have observed.

There is disagreement about the extent to which hospitals can continue to reduce costs. In addition, overall patient margins reflect discounts and other competitive pressures from non-Medicare payers. Moreover, overall patient margins reflect hospitals' total admissions and all the services provided, including losses associated with patients who have no insurance coverage and cannot afford to pay their bills.

The distribution of median total and patient margins across hospital groups is generally similar to the pattern of first-year PPS margins. Rural hospitals had lower median total and patient margins, although the difference between rural and urban margins was much smaller than in the case of PPS margins. Median margins for hospitals in the larger bed size groups were higher than for their smaller counterparts.

Again, rural hospitals with fewer than 50 beds show substantially lower median margins. The median total margin for this group was 3.3 percent. The median patient margin was -3.7 percent. The positive total margin may reflect the role of county government contributions to these hospitals.

The most dramatic difference between the pattern of PPS margins and overall margins is the experience of major teaching hospitals. These hospitals had a very high median PPS margin of 18.8 percent, but had a median patient margin of -4.3 percent, the lowest of any group reported. The total margin for major teaching hospitals was somewhat lower than other hospitals as well. The low median patient margin for these facilities may reflect the costs of new treatment modalities, clinical research, and educational costs that are not reimbursed through patient revenue. The difference may also reflect a larger proportion of uncompensated care.

## More Study Needed

This analysis and others indicate that, on the whole, the hospital industry is financially healthy, especially with regard to Medicare costs and revenues. Some hospitals, however, are having difficulties. More study is necessary to estimate how policy changes since PPS implementation have affected the financial health of hospitals. Data for one year neither reflect trends nor show the long-term effects of PPS. Further study is also needed to determine how the financial vulnerability of hospitals, particularly those in isolated rural areas, affects beneficiary access to care.

## Updating the PPS Rates

ProPAC believes that the best way to use this information about hospital margins is to better inform the process of updating the PPS rates. One consideration in this updating process is whether the cost data that was used to calculate the first year PPS margins should also be used to adjust PPS standardized amounts.

Using the first year PPS cost data, we can compare the costs which were projected for the first year of PPS with actual costs. You will recall that when the PPS was begun in fiscal year 1984, we did not have current actual costs. Rather, the actual costs for fiscal year 1981, the most recent data that were then available, were used in developing the rates. Those 1981 actual costs were updated to fiscal year 1984 and the Congress specified that the initial rates for FY 1984 and FY 1985 be "budget neutral" to spending under the TEFRA limits. Since the first year of PPS, the amounts have been updated -- by 3.4 percent in FY 1985, by 0.5 percent in FY 1986, and by 1.15 percent in FY 1987.

Now, however, we have actual hospital cost data for the first year of PPS. We find that if we replace the updated 1981 costs with these new actual first year PPS costs, the standardized amounts are lower. The amount of the difference -- which ProPAC has estimated to be about 13 percent for urban hospitals and 7.6 percent for rural hospitals -- is comparable to the margin figures which we are discussing today.

ProPAC anticipated the availability of actual cost data and recommended in the past that standardized amounts should be recalculated when first year PPS cost data were available. This is not because we favor a return to a cost-based system. Rather, we believe that industry-wide cost information is an important part of informed decision-making about future payment rates for hospitals. We recognized, however, that there is no simple way that more current cost information could be used in setting payment rates, and that substantial judgment would be required.

Considering Margins and Actual 1984 Costs in Updating the Rates

The Commission will meet on March 2-3 to make final decisions about our recommendations for a FY 1988 update factor. In addition, much of the information I have described this morning on hospital margins is included in our February report to the Congress, which will be printed in a few days. Because we were aware of your interest in hospital margins and the difference between actual and projected costs, and because of the impact of both of these subjects on the update factor, Commissioners discussed this information at our February meeting. The positions which I am describing to you today are informal and subject to change at our upcoming March meeting. But the ideas I will suggest reflect the general consensus of Commission members about the way we believe this information should be incorporated into the policy process.

ProPAC does not view this problem as a simple arithmetic exercise. Viewing 15 percent margins or a 12 percent difference between actual and projected costs should not lead to the conclusion that PPS rates can or should be decreased on this order of magnitude. Several factors are important in arriving at an appropriate decrease.

Basic Concerns in Using Margins and Cost Data

One basic concern is that the prospective payment system was designed to encourage maximum efficiency on the part of hospitals. This means that savings realized from the PPS program due to efficiency gains should be shared with the hospitals. This has been an integral part of ProPAC's approach to each year's update factor, and we strongly believe that this concern should be reflected in whatever actions are considered for this year's update factor. If you design an incentive-based system and then take away all of the gains resulting from actions taken to respond to the incentives, you have undermined those very incentives which you so carefully designed in the first place.

Another problem which should be considered is that hospitals are having different financial experiences under PPS. Even if the hospital industry as a whole has received payments which are greater than anticipated, individual hospitals could suffer dramatically if we cut the system in an indiscriminate way.

Yet another concern is problems associated with moving to large cutbacks without warning and time for adjustment. Thus, you may wish to consider some phasing of any sizeable reduction in the level of payments.

Finally, we need to take into account what has happened since the first year of PPS. Update factors for FY 1985, FY 1986, and FY 1987, for example, were considerably below inflation in hospital costs of doing business in those years. Nevertheless, increases in per case payment levels have been far higher than the update factors.

## Factors to Consider in Decreasing Payment Rates

The Commission has recommended that once cost data reflecting hospital experience under PPS became available, the standardized amounts should be recalculated. The current information about first-year margins and lower than expected costs leads to a clear indication that a reduction in the standardized amounts should be considered.

As the Commission has noted in its previous recommendations regarding recalculating the standardized amounts, a great deal of judgment is required in deciding how to use this information in setting the appropriate level of PPS payments. There are several important considerations in reaching this judgments.

## Sharing Gains With the Hospital Industry

One issue to consider in deciding how to use these results is the extent to which hospitals should share in the gains from PPS. In its previous update factor recommendations, the Commission has argued that productivity gains should be shared among the hospital industry, the Medicare program and Medicare beneficiaries. This would argue against adjusting PPS rates to reflect the entire difference.

On the other hand, some of the reductions in hospital costs may reflect shifts in the site of care. For some patients, outpatient treatment is now substituted for part of an inpatient stay. This shift may result in higher Medicare payments to hospitals or other providers for outpatient treatment. In its update factor recommendations, the Commission has taken the position that cost reductions due to shifts in the site of care should not be shared with the industry.

## How Much Have Hospital Payments Already Been Lowered?

Another issue is the extent to which PPS payments have already been reduced as a result of hospitals' early PPS experience. Although the cost data weren't available, there were indications that hospitals had responded to PPS incentives -- particularly by shortening length of stay -- and were doing well financially. This general assessment was reflected in the relatively low update factors in fiscal years 1986 and 1987. In addition, most of the savings from the reduction in indirect teaching payments enacted under COBRA were removed from total PPS payments.

On the other hand, PPS per case payments have risen much faster than the market basket, primarily because of unexpectedly large increases in the case-mix index. Current estimates indicate that this trend will not hold in fiscal year 1987, partly because of the reduction in the indirect teaching allowance.

The movement to national rates also leads to an unintended increase in PPS payments. The 1981 data on which the federal amounts are based was not audited. The hospital-specific amounts were audited, reducing the base by about 4 percent. Therefore, payments under the two components are not equal, and the transition from hospital-specific to national rates inadvertently increases payments to hospitals by about 1 percent for each full year of the transition.

This auditing effect is not reflected in the 12 percent difference between updated 1981 costs and first-year PPS costs. The first-year PPS data was audited for less than one quarter of hospitals. In addition, the auditing focused on capital costs. Comparison of audited and unaudited first-year reports for the same hospitals show that operating costs were reduced by less than 0.5 percent as a result of auditing.

Summary

These considerations can be used to support adjustments in the standardized amount which will decrease payments 3 to 8 percent. Determining a specific adjustment within this range depends on judgment, as I have stressed several times today. This adjustment would precede usual updating of the rates for fiscal year 1988.

My own view is that the appropriate range is 4.5 to 6 percent and that any adjustment should be phased in over three years, generating a yearly reduction in the standardized amount between 1.5 and 2 percent.

ProPAC has attempted over the past several years to balance budgetary and financial prudence with the need for assuring that Medicare beneficiaries have access to high quality hospital care. We will once again be trying to balance these needs when we discuss all of the data and information presented to you today. We will also review a great deal of additional information about hospital productivity, scientific and technological advances, and case-mix change at our March 2-3 meeting. Our formal update recommendations for FY 1988 will be based on our discussions and a review of all of the available data.

I anticipate that our recommendation will reflect judgments reached after weighing all of the concerns we are discussing today. I will see that the members of the subcommittee and your staff receive our formal recommendations as soon as they are available after the meeting.

We look forward to continuing to work with you on these urgent public policy issues. Thank you for giving us the opportunity to testify today.

Chairman STARK. You sound sort of like a combination of my internist and the guy at the auto garage when I take my car in for service. There is a problem there, but you are not quite sure how to solve it. [Laughter.]

Mr. ALTMAN. Well, for a fee. [Laughter.]

As a university professor, I need a grant to study this. [Laughter.]

Mr. DAUB. A consulting contract.

Chairman STARK. Mr. Simmons?

**STATEMENT OF LARRY K. SIMMONS, DEPUTY ASSISTANT INSPECTOR GENERAL FOR HEALTH AUDITS, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY GEORGE REEB, DIRECTOR FOR HEALTH CARE FINANCING AUDITS**

Mr. SIMMONS. Good morning, Mr. Chairman and members of the committee. With your permission, I will just give you the highlights of my testimony and submit it for the record.

We welcome this opportunity to appear before you today to discuss our interim report on hospital profits and losses during the second year of Medicare's prospective payment system, 1985.

Since implementation of PPS nearly 3½ years ago, there have been many requests to the Office of Inspector General about whether there were sufficient funds available to pay for quality health care of our beneficiaries in hospitals.

Last year, our office provided testimony before the Senate Finance Subcommittee on Health about the substantial Medicare profits our review determined were being earned by hospitals during the initial year of PPS, 1984. Our followup survey of Medicare profits during the second year of PPS, 1985, is an extension of that earlier review.

Our new survey covered sample hospitals' cost reports for PPS in fiscal years ended September 30, 1985, through August 31, 1986, a fairly current period. Our sample is nationally representative of all hospitals participating in PPS during 1984 and 1985.

At present, our analysis for 1985 is only about 98 percent complete due to incomplete or incorrect data from three of the 236 hospitals in our sample. However, we do not anticipate that the final results will differ materially from those summarized in our interim report.

With your permission, Mr. Chairman, I will submit our interim report on 1985 PPS profits for inclusion in the record. That report was just issued yesterday to the Administrator of the Health Care Financing Administration.

In our 1985 review, using the 233 hospitals' unaudited cost reports for PPS year two, we computed Medicare profits for each hospital and related the amount of profit to Medicare revenues; that is, we computed a Medicare profit rate. Next, we computed the weighted average profit rate for all the sample hospitals in 1985 and compared the 1985 and 1984 weighted rates.

Using this methodology, we concluded the following: First, 1985 hospital profit rates from PPS average 15.27 percent, up from 14.18 percent in 1984, a little over a 1-point increase. Second, 1985 PPS

hospital profit amounts averaged $1,037,000, up from $939,000 in 1984, about 10.44 percent improvement.

Projected total net PPS 1985 profits for all hospitals increased by about $500 million, from an estimated $4.6 billion for 1984 to $5.1 billion in 1985, and that is Medicare profits, PPS alone.

1985 Medicare inpatient discharges decreased by 5.63 percent at the surveyed hospitals.

Eighty percent of the surveyed hospitals earned PPS profits in 1985 and 20 percent incurred a loss. That was the same result in 1984.

Since we used a random sampling technique, the high and low boundaries of our profit rate estimate can be mathematically determined. We are 90 percent confident that the estimated 15.27 percent profit rate for 1985 has an upper limit of 16.91 percent and a lower limit of 13.63. The 15.27 percent is the midpoint.

In our analysis, we defined Medicare profit as the difference between a hospital's reported Medicare inpatient revenue and Medicare inpatient costs. In determining Medicare inpatient revenue, we included return on equity, DRG revenue, outliers revenue, and indirect medical education payments.

In developing Medicare inpatient operating costs, Medicare pass-through amounts such as capital, direct medical education, and bad debts were not included since these items are reimbursed independently of the PPS mechanism. Inpatient revenue and cost amounts were extracted from the sampled hospitals' Medicare cost reports for each of the 2 years that we are talking about, 1984 and 1985.

We believe the large PPS year one and PPS year two Medicare profits occurred in part because the PPS Federal rate is based on overstated hospital inpatient operating costs. Our prior audits and those of GAO concluded that the 1981 cost data that HCFA used to construct the rates were overstated.

We have previously recommended, in our 1984 report, that HCFA rebase the PPS rates using audited cost data to correct for deficiencies in the present data and to reflect hospital behavior under PPS incentives. Our report again restates that recommendation because it has not been acted on by HCFA.

We are recommending that HCFA clarify the legal basis to rebase. If a legislative change is required to do that, we are recommending that HCFA get legislative authority to recompute the DRG rates using more accurate and audited cost information.

We are also recommending that HCFA rebase the DRG rates after the full transition has been made to a 100-percent Federal rate. This will allow for the DRG rates to be developed utilizing to the fullest extent hospital behavior under the PPS.

Pending this action, we recommended that HCFA consider the profit rates that we reported to them in our 1985 report in recommending the level of increases in PPS rates during their annual updates.

That concludes my testimony, Mr. Chairman. I will be happy to answer questions.

[Statement of Mr. Simmons follows:]

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decide is appropriate for technology, reduced for productivity and the adjustments for case mix and so on.

So, next week, Monday and Tuesday, the Commission will be completing our assessment and we will make a recommendation to you. I think it is important that that update process continue because for better or worse, it is developing some degree of continuity.

I would like to see, in the future—I personally would like to see it become less political and somewhat more mechanical.

Mr. GRADISON. Yes?

Mr. COHEN. I would just like to mention as an example of the problem associated with what has already been taken away. In the update factor from 1984 to 1985, there was a clear recognition that hospitals had substituted care in the outpatient setting for care in the inpatient setting, and as a result the update factor was reduced as it should have been, because Medicare should not have paid twice.

At the same time, the 1984 cost report information which you now have in front of you reflects the shift that occurred in 1984. I mean, the inpatient costs in the 1984 cost report are in part lower than they were predicted to be precisely because hospitals did shift some services to the outpatient basis.

Therefore, if you simply apply historical update factors to the 1984 costs, you are double-taking away from the hospitals. It has to be one or the other. I mean, neither should Medicare pay twice nor should the hospitals give up the money twice. So that is why you cannot simply take the 10 percent and subtract it from the current standardized amounts.

The next thing that I would point out is that, in addition to being involved with ProPAC, I have been running a hospital rate-setting program in Maryland for quite a while, and I am quite conversant with what tough hospital rate-setting programs do. In general, the history has been that market basket plus 1 percent a year has been much tougher than the Federal program in the aggregate when you adjust for what I would call not real case-mix change; that is, you have to pay for real case-mix change, but you don't pay for reporting case-mix change which is not real.

If you reduce the original base by about 12 percent—that is, if you take the newly estimated 1984 costs, and you said, We will treat them the way the toughest systems have treated them, which is market basket plus one—then what you wind up with in 1988 are payment levels equal to 1987 payment levels.

So the outside conclusion that I would come to would be that the whole system would have been essentially taken away from the hospitals by the end of next year if you paid next year the same thing as this year. What Stuart has proposed is that the remaining 4.5 to 6 percent be spread over 3 years rather than taking it all away in the next year by essentially freezing.

Mr. GRADISON. I am sorry; I am confused. If we, in the next year, pay market basket minus two, which is the current statute, what further adjustments are necessary, in your opinion? Is it 1.5 to 2 percent a year for each of 3 years? Are you agreeing with Stu or not? I am not sure I understand that.

Mr. COHEN. All right. What I was saying is that there is a gap between what the hospitals—the 1.5 to 2 percent is the total amount that Stuart has identified. The question largely is, do you do it over 3 years? The other question is, is market basket less 2 percent what the law would be if hospitals had been in the red they would have been in, if they had been paid what the costs were in the past?

What I am saying is that if you were paying hospitals at market basket plus one rather than market basket le s two, which is what the law was when this started and what the toughest systems have worked on, then next year you would wind up with market basket less about five, and since the market basket is five, you would wind up with a freeze in payments.

Mr. GRADISON. Thank you. I understand, and I appreciate that clarification.

Does anyone else have any thoughts on what we ought to be doing overall?

Ms. GORDON. As you know, CBO does not have thoughts on what you ought to do, but I do have thoughts on how you might gather some information to help you decide.

Chairman STARK. Raise your hand.

Ms. GORDON. Well, sometimes I have personal opinions, but I have to keep my mouth shut on those. I cannot raise my hand here. But I certainly agree that it is extremely difficult to figure out what has happened and what ought to be done.

There are two points I think might be borne in mind. One is that the situation has changed considerably since 1984. The 1984 data tell us about increases in efficiency and increases in case mix and so on, up until those data were collected. They do not tell us what has happened since then.

That, I think, is particularly important if you are looking at patterns of operating margins such as ProPAC has displayed. Both the movement to national rates and the changes in the system that the Congress has enacted—for example, in SOBRA—are changing the relative positions of some of the hospitals. As a result, one would not necessarily expect rural hospitals to have as low operating margins relative to urban hospitals in the future as they had in 1984, for example.

One of the possibilities would be to start with the 1984 data and make use of what we know has happened since then—say, in terms of inflation—and try to figure out where the methodology for the past updates would have taken us had we had the information then that we have now.

That is not a simple task. There are many areas where we still don't know very much, but we do know quite a bit more now than we did then.

Mr. SIMMONS. I will sort of have to pass on it, Mr. Gradison. In our Department, as you know, the recommendation for the update factor comes out of HCFA. What we are suggesting that they do is consider the amounts of money made in 1984 and 1985 in recommending that factor.

My personal view is that our recommendation to rebase seems to me a reasonable recommendation in the sense that if we don't rebase until sometime in the future, we should not leave the pay-

So, if I had to weigh all of those, I would not expect to see teaching hospitals doing as well.

Ms. GORDON. One way to summarize all of this is that we all turned our attention to the different factors that affect hospitals' payments and that are distributed differently amont regions. The regional adjustments, in essence, merely reallocate the PPS payments among different regions—if payments go up someplace, they must go down someplace else by the same amount.

As those regional adjustments phase out, that redistribution disappears. In other words for any given region, to find out what happened to that region, you have to look at the characteristics of the hospitals in that region that affect PPS payments and see how they interact with changes in the system such as the move to national rates. So we are really answering, I think, a more complicated question than you asked.

Mr. DONNELLY. Do you have the geographic data on which your study was based?

Ms. GORDON. I am sorry?

Mr. DONNELLY. Do you have the geographic component that you used for study?

Mr. ALTMAN. Yes, they have. Included in my testimony are tables 1 and 2, which are broken down by region. And anything that you don't have, you are welcome to.

Mr. PICKLE. Will the gentleman yield?

Mr. DONNELLY. I will be happy to yield.

Mr. PICKLE. When you talk about the cost by regions, are you talking about disproportionate share or the entire——

Mr. ALTMAN. No, we are talking about 1984, so the disproportionate share adjustment took place after that.

Mr. PICKLE. Well, if you have it—maybe in this document you don't—I would like to see, by regions, what are the figures for disproportionate share. If you can give that to me, I would like to have that.

Ms. GORDON. Yes.

[The material follows:]

TABLE 1. ESTIMATED DISPROPORTIONATE SHARE PAYMENTS BY CENSUS DIVISION, FISCAL YEAR 1987 a/

| | Disproportionate Share Payments (In millions of dollars) b/ | Percent of All Disproportionate Share Payments | Disproportionate Share Payments as a Percent of Total PPS Payments |
|---|---|---|---|
| All Hospitals | 545 | 100 | 1.3 |
| Census Division | | | |
| East North Central | 91 | 17 | 1.3 |
| West North Central | 23 | 4 | 0.7 |
| Mid-Atlantic | 107 | 20 | 2.3 |
| New England | 18 | 3 | 0.8 |
| East South Central | 40 | 7 | 1.8 |
| West South Central | 56 | 10 | 1.6 |
| South Atlantic | 95 | 17 | 1.8 |
| Mountain | 7 | 1 | 0.5 |
| Pacific | 108 | 20 | 2.2 |

SOURCE: Preliminary Congressional Budget Office estimates.

a. The disproportionate share adjustment is only applied to the federal portion of a hospital's payments. CBO estimates that in fiscal year 1987, 62 percent of PPS payments are based on the federal rate. Therefore, if the system were fully implemented in 1987, total disproportionate share payments would be larger than shown here—$880 million or approximately 2.1 percent of total PPS payments.

b. Approximately 98.5 percent of the disproportionate share payments are made to urban hospitals.

Mr. COYNE. Thank you, Mr. Chairman.

Dr. Gordon, your study indicates that of the 12 percent margin, 6 percent can be attributed to cost-cutting by the hospitals. I wonder if you could tell us what areas that cost-cutting came in, if your study reviewed that.

Ms. GORDON. The various sources of that reduction include, first of all, real improvements in efficiency—that is producing care using either less expensive or fewer resources to do so. But another portion of that reduction in cost may have come from the site-shifting that has been talked about—moving some services that were previously provided in the hospital out into other areas.

A third factor that may have occurred, but one on which there is just no information is that the quality of care may have gone down. All of those various things are lumped together as cost reductions, and it is just not possible for us to separate out those factors.

Mr. COYNE. Did the study do any review about what appears to be an explosion in the advertising budgets of hospitals—billboards, television ads?

Ms. GORDON. No. Our study is based on the cost reports filed with the Health Care Financing Administration and does not use that detail.

Mr. ALTMAN. Mr. Coyne, we have been studying productivity in some depth, and this year, in our report which will be sent to you in April, we will be presenting you with a lot of information on what hospitals have been doing.

What is interesting from my point of view is, I don't share the optimism in terms of productivity advances after 1984. This is not because I did not expect it but because the numbers do not seem to reflect it.

There was an initial reduction in cost that took place right after PPS got going, but it becomes harder and harder to see it as you move on. We are going into minute detail looking at staffing ratios by department, looking at quality measures, whether it is in intensive care. On the positive side, we are not seeing the so-called reductions in quality that some people are screaming about. But, on the other hand, we are not seeing the reductions in expenditures that you might have expected.

For example, FTEs, or employees per admission, have continued to rise. The number of FTEs, the number of employees in hospitals, has gone down, but admissions have gone down faster. Now, I am not saying that is necessarily a bad thing. But I do believe that if hospitals were really faced with tough financial limits, which they have not been, we would have seen that.

So that is one of the reasons why I am not so sure we are going to see those margins stay up there.

Mr. COYNE. Is there any analysis of, for instance, the nurse-to-patient ratio?

Mr. ALTMAN. Well, as I said, the FTEs, or total employees, a great bulk of whom are nurses, per patient, have gone up and continue to go up. Now, there is a good reason for part of that, and that is that the patients are sicker, and so, again, I am not being critical of that number. But it has not gone down.

Mr. SIMMONS. Our data base that we are building and have built for over 233 hospitals in 1984 and 1985, when it is fully up—and we

are not there yet—but when it is fully up, we will be able to provide information on cost per Medicare discharge in 1981, 1982, 1983, 1984, 1985, and as long as we elect to track it, that will give us an indication about whether, in the aggregate, the cost behavior is going up or going down and compare that with the profit amounts. We don't have the data yet; we should have it within a month.

Mr. COYNE. Dr. Altman, what has been the effect on rates of the readmission of patients within 30 days of the initial admission?

Mr. ALTMAN. We have been looking at that—what we call the transition patients—more in terms of quality than cost. I don't think there has been a big cost impact. We have not studied that specific issue. But we are concerned more about that as a quality problem, and that is that people are being let out of the hospitals too quickly after being forced back in too quickly. We are halfway through that study, and as soon as it is available, we will be glad to give it to you.

Mr. COYNE. Thank you.

Chairman STARK. Mr. Pickle?

Mr. PICKLE. Well, I would just like to ask the panel a general question. When we established the PPS or the DRG system in 1983, we were trying to set up a system that would make the hospitals as efficient and as cost-accountable as possible. They were in difficulty, and we had tried all kinds of approaches before that time, and we set the DRG's.

Now, apparently, the system is working; at least we are in much better shape than we were 3½ years ago. I hope we don't lose sight of the fact that we are trying to maintain efficiency in the hospital more than we are just trying to affect revenue. That is a temptation.

I am concerned that if we make any drastic rebasing, as you call it, and as apparently some of you recommend, that we would do that at the cost of efficiency to hospitals. The system is working. My question to you is—and you can give me a general yes or no as quickly as you can—if we make this rebasing or adjustment along the lines some of you recommend, although there is variance in it, do we run the risk of reducing efficiency and weakening the system that we have set up that is working? Are we going to lose efficiency in this process just for the effort of raising revenue?

Mr. SIMMONS. Mr. Pickle, I believe it does raise that possibility, but by the time we rebase it, if we rebase it, if and when we rebase it, hopefully, the peer review organizations will be at better efficiency than they are now and be able to address that problem. In other words, the quality-of-care issue, the mechanism in our system is peer review—and peer review is a relatively new concept—if we rebase somewhere out there in the future peer review organization are in place to guard against that thing happening that you are talking about.

Mr. PICKLE. It ought to be reviewed, and ProPAC ought to be doing that, although we are doing it a year earlier than ought to be expected.

Mr. ALTMAN. You gave us four as the outside. We are trying to do it a little earlier.

a little more comfortable with leaving us short of 100 percent until we knew a little more.

Mr. DAUB. So you don't look at the movement to the national rate in the same way you look at the cost adjustment each year, something you said we were rather comfortable with now? We need to do that?

Mr ALTMAN. I think that there are winners and losers of moving to national rates that have absolutely nothing to do with efficiency, and we have not wrung all of the inefficiency out of the system. And anybody that tells you that we have, I would love to talk to them.

Mr. DAUB. Would anyone else care to comment?

Ms. GORDON. Yes, if I might. I think there is a great deal of attention on the update factor that moves the rates each year, but many other things affect how much hospitals are actually paid by Medicare. If you look, for example, at Medicare's payments per case under the PPS, as best we can tell, they are higher than they would have been under TEFRA because of such things as the case mix adjustment.

PPS sets a price for a certain condition, but when you have recoding, then you are paying higher prices than before whereas TEFRA said that the Federal Government is going to control payment per case. I think that factor is something that should be considered.

The other thing to remember is that capital costs have been reimbursed outside of the PPS, and fully reimbursed up until 1987. Now, starting in that year, hospitals are not being reimbursed for all of their capital costs.

And so the concern about capital markets and the funding of investment by hospitals, I think, is a factor to bear in mind as you consider what to do about possible changes in reimbursing capital costs, rather than one that is directly relevant to the PPS payments for operating costs.

Mr. DAUB. What my rural hospitals are telling me is that they had these enormous savings, and in fact they felt their margins were better the first year, and they now look at it being harder for them to forge, as you have indicated, this change in their margin. The CBO tables on urban versus rural, 13.1 versus 6.9, show the disparity, if I may use that term, between urban and rural.

Ms. GORDON. Yes.

Mr. DAUB. And I do not know what the regional breakout would be on urban and rural, but out in corn and cattle and bean, hog, and wheat country, with little tiny hospitals and a small number of beds, it is really disparate.

Ms. GORDON. I think that your rural hospitals, in their own interest, should very much focus on the difference between rebasing and changing the aggregate level of payments. If rebasing were done in a totally budget-neutral fashion, rural hospitals would come out ahead.

Mr. DAUB. Yes.

Ms. GORDON. It is when you combine rebasing with reductions in aggregate PPS payments that you find that they would still come out ahead compared with urban hospitals but not necessarily——

Mr. DAUB. I guess that is what I would worry about, whether it is minus 3 or minus 4 or minus 5, Hal, like you said, and that would bother me a lot. I don't know if that would help.

Mr. ALTMAN. I think, as an issue, we have spent more time, appropriately, on the rural issue this year than any other issue. We have made and will make several recommendations to you last year and this year about making the system work in an even way.

Hal may want to comment since he has done most of the work, but one of the things we have found that can be very helpful to rural areas is to make a distinction between rural-rural and urban-rural and to change the wage adjustment. We also have made that recommendation with respect to urban areas. We have found that suburban areas often have benefited from being tucked into SMSA's where the high wages are really being paid by urban-urban, so that we are going to make that recommendation.

Mr. DAUB. Sure.

Mr. ALTMAN. So, hopefully, the system, over time, if we keep our eyes on it, will be fairer, but your rural hospitals have been hurt.

Mr. DAUB. I do have some legislative language that I drafted that I will be offering as an amendment or two along these same lines later on in our proceedings as a committee. I found, with respect to hiring nurses, that the rural hospitals near a urban metropolitan statistical area were quite disadvantaged in regard to part-time versus full-time employees. Still, with the amendment on the area wage index, we were not quite accurate.

Then I go further away from the urban area, and I find a hospital that is a mental institution, State-run, in the same town with just a regular hospital, and there is a real disparity of reimbursement. Of course, the State institution can attract higher reimbursements, and therefore it can pay its nurses more, and then everything is really out of whack. So there are some things that we need to look at, and I appreciate it.

That is all, Mr. Chairman. I appreciate very much this panel. I think you have been very helpful to us, and we look forward to continuing receiving information from you on these very tough subjects.

Chairman STARK. Mr. Levin?

Mr. LEVIN. Thank you, Mr. Chairman.

I am sorry that I had to leave to go to a Trade Subcommittee meeting briefly, and so perhaps my concerns have been asked. I was going to focus in on disaggregation of the figures and what the 12 percent really meant, and maybe you have covered that well.

I noticed, in Dr. Altman's testimony, there was a lot of disaggregating, though I am not sure of the impact. Table 1 would seem to indicate, if I read it correctly, that it would mean 50 percent of the hospitals are between 3.8 and 17.9. Is that what that means?

Mr. ALTMAN. Yes, that is right.

Mr. LEVIN. So let me just ask you—and if you have covered this, tell me, and if you would, Mr. Chairman, go on to the others—how significant that spread is in terms of getting at the issue. What is the meaning of that kind of spread, not so much as mathematicians but in terms of the health field?

our economic life on the basis of samples. We are all guessing in updating PPS now, and it is wrong.

Mr. MOODY. Well, it seems to me that it might be very dangerous to make any policy changes based on 1984 data when all of you agree that there have been significant intervening changes that have not been reflected in the data we are looking at. So it seems to me that is a very good suggestion, I would think, that we should institute a sampling system. After all, we can get down to pretty small margin errors with sampling techniques.

Mr. ALTMAN. Yes, sir.

Mr. MOODY. I would hope, Mr. Chairman, that the committee might make a recommendation in that direction.

Mr. SIMMONS. Of course, Mr. Chairman, we did a sample in 1985, and the statement about the delay in the cost reports is real. Two hundred thirty-three out of 236; we still do not have 3 of them. We still do not have some for 1984, so it is valid concern. We all share it. How to get them in faster is a $64 question.

Mr. ALTMAN. It is a $64 million question.

Mr. SIMMONS. Yes.

Mr. MOODY. Mr. Chairman, could I ask another question?

Chairman STARK. Go ahead.

Mr. MOODY. Let me now change the focus of my questions. We have been talking about rebasing and the obvious problems with that. We all agree, I think, that we want a system where we maintain the incentives at the margin for efficiency, so any recapture program of operating margins could, if it is poorly conceived, hurt that.

I would like to have your reaction to a regime whereby we recapture some proportionate share of the overage or whatever term you want to use, but not the whole thing. A flat percentage reduction in the base, for example, would, as you say, cause real distress and wipe away incentives at the same time—both bad results—whereas a flat percentage of the margin would continue the incentive to remain efficient but would still return to the taxpayer and to the deficit reduction effort some real dollars.

In private markets, it would be analogous to a profits tax versus an ad valorem tax on sales. An ad valorem tax on sales would destroy incentives for many firms, whereas a profit tax always allows the entrepreneur to maintain some share of his efficiencies, and therefore the incentives are continuous.

What would you think of a regime where we might look at, let's say, recapturing half of the margin but never wiping it out for any one hospital?

Mr. ALTMAN. The economist in me says you should not do that because you are going to penalize those that have been the most efficient and have attempted to do the most, and you are going to make their percentage higher because they have earned more.

Mr. MOODY. How about not a graduated regime but a flat one, so that those who have been the most efficient and have saved the most keep the most, but they do not keep every dollar?

Mr. ALTMAN. Yes. The public policy side of me says that we ought to be able to come up with something that accomplishes something closer to that.

Chairman STARK. Would the gentleman yield to let me piggyback on that?

Mr. MOODY. Certainly.

Chairman STARK. I was going to ask you, one, if, politically or realistically, we should let some hospitals close or go broke because we have got a 60-percent utilization. You might comment on that. Should we let some go broke?

Then, second, the question is, should we let them go broke on a basis of those who cannot make a profit, you protect, say, a disproportionate share in rural hospitals and then let them go broke on a basis of whether they make enough money or not? Or should we have a system for deciding who goes out of business and try to do it on some other basis than the market?

Mr. ALTMAN. I don't think you want to let them go broke because you have just come up with some artificial formula that wipes out a big chunk of dollars. But I do believe that, over time, we need to reduce the number of hospital beds. I don't think anybody seriously questions that.

One of the mechanisms for making this decision is to let the patients decide, and therefore those hospitals that do not have enough admissions should close—whether they go out of business or merge in some way. We have to be very careful in rural areas that we do not continue to prop up a lot of hospitals that should not be in business.

We are going to make recommendations to you which try to balance those out. Even our rural representatives recognize that. We want to protect those little hospitals that have wide swings, but we do not want to protect those that have had permanent reductions in admissions unless we decide, as a public policy, that this hospital is 100 miles away from everybody else and should stay even though it is at 50 percent occupancy.

So I am sympathetic to Mr. Moody's concern and we might want to take a look hospital by hospital, but not do it across the board.

Mr. MOODY. Any other comments on my proposal?

Mr. LEVIN. Would you yield?

Mr. MOODY. Sure.

Mr. LEVIN. I wanted to go back to your question. Are these disaggregations at all meaningful, then? I mean, I think you have gotten at the question about the lack of currency of data. So what do they mean? I mean, are they the basis upon which to act?

Mr. ALTMAN. I do think they do give you some very important pieces of information. They indicate, at the aggregate level, that costs were substantially less in 1984 than was expected in 1981, and they are the basis on which you can decide whether you want to continue these payment levels those forward. At an overall level, I think they do give you an important piece of information.

Second, I think it suggests differences across regions and types of hospitals. I suggests that it was not all in one region, and that the differences, as Mr. Moody said, are far lower across regions than they are within.

So, as I interpret them, you should not worry so much about regional differences. What you need to worry about, however, are differences in rural versus urban, teaching versus nonteaching, subur-

Ms. GORDON. I think you were exactly right—that you have to decide how you feel about looking at Medicare separately. Should Medicare continue its tradition of paying only for Medicare beneficiaries? If so, should something else be done about, say, uncompensated care? Or do you want to have cross-subsidization occurring, and so on?

I think all this contributes to making a more difficult decision. But the economist in me certainly agrees with you that the incentives for efficiency would remain.

Mr. MOODY. Thanks a lot.

Chairman STARK. Thank you.

If none of the other members have any further inquiry, I want to thank the panel very much. I look forward to working with all of you in the months ahead as we try to resolve this issue. I appreciate your input and look forward to ProPAC's recommendations, which we will see soon.

Mr. ALTMAN. Thank you.

Chairman STARK. Thanks very much.

I would announce to the members and the audience that the Chair is prepared to ignore the rumbles of your tummies and work right through lunch and see if we can conclude the hearing. It is my understanding there will be no votes. So those of you who may be on panel III and may want to go across the hall for a sandwich might be advised that we will go right through.

The second panel is Dr. Carol McCarthy, president of the American Hospital Association; Mr. Duane Dauner, the president of the California Association of Hospitals and Health Systems; and Mr. Howard Newman, an associate of Powell, Goldstein, Frazer & Murphy.

I am going to ask this panel, whose prepared testimony has been distributed to all of the members, to attempt to summarize their prepared testimony in approximately 5 minutes. I assure you we will extend your remarks based on the inquiries that members will have as a result of your testimony, but I think we can move the hearing along a little more expeditiously if the witnesses will cooperate in that, and I will ask you to proceed in whatever manner you are comfortable in the order that I recognized you.

Dr. McCarthy, proceed.

## STATEMENT OF CAROL M. McCARTHY, PH.D., PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Ms. MCCARTHY. Thank you, Mr. Chairman.

I would like to make a number of points that are included in testimony that has been submitted. First of all, the opportunity for hospitals to earn a surplus, if you will, was part of the design of the PPS system, and necessarily so.

It was to move hospitals to more efficient operations and to contain the costs of the Medicare program. The most recent data available indicate that between 1984 and 1986, in fact, Medicare expenditures were reduced $13 billion below what would have been anticipated without the prospective payment system, so that, No. 1, Medicare has in fact achieved the savings it sought through the PPS system as currently designed.

Second, that opportunity to earn a surplus is essential because what we introduced was a revolutionary change in financing for hospitals. Hospitals were at risk not only for their efficiency or inefficiency but also for the type of patient they were going to treat because, as you know, we are talking in DRG rates about an average cost per patient, and if you get a nonaverage or high-cost patient, it is simply the luck of the draw and you have to rely on your surplus to in fact provide the reasonable and necessary care for the patient.

Related to that is the fact that, from year to year, there are fluctuations in the patients that are treated and in the costs that are incurred, so that any one year is not a good indication of where a facility might be.

Third, on the profit data itself, there are at least three major problems. First of all, it is not recent data. Second, it is very influenced by the cost-finding techniques that are used. And, third, it is average data.

Let me speak to the first. We are looking at 1984, and I will speak briefly about the 1985 figures just released this morning. But we are looking at 1984. Since that time, as you know, we have had price increases, DRG update increases, that are significantly below hospital market basket inflation. A conservative estimate would show inflation at 19.5 percent and the price increases at 9 percent, so that we have had a 10-percentage point reduction in the real payments to facilities since the PPS payment system began.

Second, our data show some very disturbing factors on hospital patient revenue margins in 1986. They show those margins declining by 68 percent in that year alone, going from about 1.9 percent down to $\frac{6}{10}$ of 1 percent.

Third, as I mentioned, the profit data themselves are a function of the assumptions you use both with regard to revenue and cost, and the assumptions made with regard to cost raise some particular problems.

It is assumed, for example, that when we say the difference between costs and revenues is 12 percent, that we have an accurate measure of costs. As we all know, what we are dealing with as a base is the definition of Medicare allowable cost, which does not embrace such matters as malpractice, if you will, and the fair apportionment of malpractice costs. It does not embrace the care for the indigent that are non-Medicare patients, and it does not embrace a number of other day-to-day operating factors.

But, even more important, there are basic assumptions in the whole cost-reporting approach under Medicare. It is assumed, for example, that the severity of illness is average across patients, and yet that is just not the experience in treating those over the age of 65. But that assumption is based into the cost method for allocating what it costs to treat Medicare beneficiaries.

Further, routine costs are assumed to be the same for all patients, Medicare or non-Medicare, and just talking a look at the comorbidities experienced by the Medicare patient disproves that point.

When you take this cost report information and you put it up against the revenue assumptions and you come out with a 12 to 15 percent profit margin, I ask you to consider this. We know that, in

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STATEMENT OF THE
AMERICAN HOSPITAL ASSOCIATION
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
OF THE
UNITED STATES HOUSE OF REPRESENTATIVES
ON
HOSPITAL SURPLUSES UNDER THE MEDICARE PROSPECTIVE PRICING SYSTEM

February 26, 1986

SUMMARY

Prices paid to hospitals for treating Medicare patients have fallen far behind inflation since the beginning of the prospective payment system. Any "profits" earned by hospitals in the first year have been substantially eroded by these below-market-basket increases.

No data are available on the adequacy of prices currently, and for fiscal year 1988 Congress has directed the Secretary to increase prices by two percentage points less than the rate of increase in the hospital market basket. Moreover, the Medicare "cost-finding" process, used to estimate 1984 inpatient operating costs, is of questionable validity because it is based on the assumption that Medicare and non-Medicare patients use the same services and incur the same costs. A more accurate method of determining the cost of treating Medicare patients would yield a more accurate--and probably lower--estimate of operating margins.

Rebasing the prospective payment system to compensate for "profits" earned in 1984 will significantly increase the number of hospitals operating at a deficit, especially those operating at a large deficit. It will exacerbate inequities already demonstrated by the limited ability of DRGs to accurately reflect the types of patients admitted to different hospitals. Finally, it violates a basic understanding about how the system is supposed to work.

Mr. Chairman, I am Dr. Carol M. McCarthy, President of the American Hospital Association (AHA). I am pleased to be here today, representing AHA's 5,600 institutional members, to discuss the issue of hospital operating margins under the Medicare prospective pricing system (PPS).

## MEDICARE AND THE FEDERAL BUDGET DEFICIT

Prospective pricing was adopted by Congress as part of the Social Security Amendments of 1983 in an effort to ensure the long-term solvency of the Medicare program. The purpose of the new payment system was to establish positive incentives that would reward hospitals for reducing the rate of increase in hospital costs. The opportunity to earn a surplus was the positive incentive. In return, hospital managers accepted the risk of incurring sizeable deficits if costs exceeded the prospectively determined prices.

The system was not enacted as part of a budget bill. The original legislation explicitly directed the Secretary of Health and Human Services to set prices

that were neither greater nor less than the amounts that would have been paid for services if the new payment system had not been adopted. In short, the new payment system was to be used to promote the "efficient provision of quality care," and not as a means of reducing the growing federal deficit. Since the passage of the Social Security Amendments of 1983, prospective pricing has, despite its auspicious beginnings, been used repeatedly as a primary instrument of deficit reduction. In federal fiscal years 1986 and 1987 the administration proposed legislative or regulatory initiatives that would have reduced DRG-based payments by $1.8 billion in fiscal year 1986 and $455 million in fiscal year 1987. In addition, substantial cuts in both the direct and indirect medical education allowances were proposed. These proposals were intended to reduce expenditures from the level that would have resulted from setting prices as directed by the original prospective pricing amendments. That is, they reduced payments below the "current services" budget, which presumably reflected a level of spending consistent with the original legislation. Although Congress subsequently intervened and increased payments by more than was proposed by the administration, the increase still yielded substantial budget "savings," and so was less than originally called for. The end result has been that Medicare has contributed disproportionately to the federal deficit reduction effort--even though Part A of the Medicare program is funded entirely through the payroll tax system.

That prospective pricing has achieved its original goal is unarguable. In the first year, the Secretary of Health and Human Services announced that the rate of increase in program outlays had fallen to the lowest level since Medicare was created. And recent reports from the Trustees of the Hospital Insurance Trust Fund have announced a substantial improvement in the solvency of the Medicare program. Despite this success, policies have been dictated by considerations other than the viability and funding requirements of the Medicare program. The adoption of prospective pricing, combined with continuing concern about rising federal deficits, increases the urgency of finding a way of ensuring adequate funding for the benefits promised current and future Medicare beneficiaries.

## PROSPECTIVE PRICING: PRINCIPLES AND PROFITS

Prospective pricing was intended, by Congress, to create positive incentives to restrain the rate of increase in hospital costs by putting hospitals "at risk" for the difference between a fixed price and costs. Hospitals that increase their efficiency earn a surplus. Hospitals unable to keep costs within the price incur deficits. That is the theory. In practice, it is important to recognize that, under prospective pricing, hospitals are "at risk" for more than their own efficiency. They also bear the risk of admitting patients who require extraordinary treatment and incur extraordinary costs. For this reason, hospitals need to earn a surplus on Medicare payments. The only alternative is to shift a part of the cost of treating Medicare patients to private patients--an increasingly difficult task in today's competitive health care system.

The "savings" that are discussed each year during the debate over the federal budget are above and beyond those that the prospective pricing system was intended to produce. Those savings were never intended to be produced by arbitrary "ratcheting" of prices. Instead, the savings were to be produced by holding the annual rate of increase in prices to a level closer to the rate of increase in the hospital market basket. Throughout the 1970s, hospital costs rose on a per case basis substantially more than the market basket. Holding the rate of increase in prices to the hospital market basket would have produced substantial savings for the Medicare program; limiting prices to less-than-market-basket increases have produced even greater savings. More important, holding the annual rate of increase in costs to the rate of inflation is a challenging goal for hospital managers. To insist on more than this, year after year, jeopardizes the ability of hospitals to provide access to high quality care without depending on subsidies from privately insured or self-paying patients.

Recently, the General Accounting Office, the Congressional Budget Office, and the staff of the Prospective Payment Assessment Commission have called attention to "profits" earned by hospitals during the first year under prospective pricing. These reports are troublesome for several reasons.

First, the data on "profits" under the prospective pricing system that are being discussed by CBO, ProPAC, and others, and that have attracted public notice, are from 1984--the first year of operation under the system. These "profits" were earned more than three years ago. No data have been presented or are available on the adequacy of prices currently, let alone the adequacy

essential element of this system. The possibility of incurring losses for reasons that have nothing to do with hospital efficiency requires hospitals to develop surpluses that can be used to offset losses during periods when an extraordinarily large number of high-cost patients are admitted. These risks are not trivial. For example, between the base year and the first prospective pricing year, many hospitals were successful in holding down the rate of increase in their costs. Yet, a significant percentage of hospitals experienced increases in costs substantially more quickly than the average. In fact, many of the hospitals that had costs below the median in the base year ended up with costs above the median in the first prospective payment year. This pattern indicates that many of the hospitals experiencing a surplus of revenues over expenses in the first year will experience losses in the second year. It is to protect against such unpredictable swings, and to prevent them from jeopardizing the ability of a hospital to continue providing high quality care to all of its patients, that hospitals overall need to earn a margin or surplus under the prospective pricing system.

The American Hospital Association supported the approach to setting prices reflected in the original statute, and opposes any effort to rebase the system for several reasons:

- As noted above, rebasing--setting prices based on Medicare cost reports submitted after the implementation of prospective pricing--is inconsistent with the original concept supported by the hospital industry. It is reasonable to expect hospitals to hold the increase in costs within the rate of increase in inflation as measured by the hospital market basket. Ideally, adjustments could be made for productivity, technology and other factors, but the necessary measures are not currently available. Until they are, AHA believes that limiting increases in prices to the rate of increase in the market basket is a reasonable goal and responsible public policy. AHA will, of course, continue to work to develop better methods of measuring other factors affecting costs, such as productivity, clinical practices and technology.

- Rebasing the system would largely destroy the incentives that are essential to the continued effectiveness of the system. To provide such an incentive, and to provide hospitals with the reserves they need to carry the substantial risks implicit in prospective pricing, hospitals need operating margins. If an adequate operating margin is provided, it is likely that little change in the level of prices will result from rebasing--unless the rebasing is manipulated to produce artifical "savings."

- Using 1984 data to rebase prices that will be used to pay for services in 1988 makes little sense. Much of the reported first year margin will have been eliminated by the 0.2 percent increase in prices during fiscal year 1986, the 1.15 percent increase in prices for fiscal year 1987, and the scheduled increase of market-basket minus 2 percent for fiscal year 1988. Without knowing what costs actually are in a more recent period, there is no way of knowing whether rebasing the system will result in prices that are substantially less than costs. Under rebasing, AHA's projections indicate that the number of hospitals operating at a deficit would rise to 43 percent and the number of hospitals experiencing a deficit of 10 percent or greater would rise to 22 percent.

- Even in 1984, available data indicate that cost report data are giving an increasingly inaccurate picture of what it actually costs hospitals to produce the services provided to Medicare patients. This problem is particularly acute as neither hospitals nor the Medicare program anticipated using cost reports to rebase the system. To ensure Medicare was not arbitrarily shifting additional costs to the private sector, an intensive effort to resubmit and re-audit cost reports would be required.

- Rebasing the system will also exacerbate the inequities that arise from the limited ability of DRGs to accurately reflect the types of patients admitted to different hospitals and the methods used to set prices. Until the adequacy of these methods has been assured and the principal deficiencies in the DRG system corrected, hospitals are at risk for far more than their efficiency. A reduction of 5 to 10 percent in prices will have a significant detrimental impact on hospital financial performance, particularly on those hospitals adversely affected by inequities that continue to exist, four years

after the enactment of the amendments that created the system. Such hospitals would have to either make significant changes in services, significantly increase charges to non-Medicare patients, or face a precipitous decline in their financial health.

- As noted in the previous paragraph, one effect of rebasing the system will be a substantial increase in the prices charged to non-Medicare patients. For example, if prices were reduced by 10 percent, it would be necessary for hospitals to raise their charges to non-Medicare patients, on average, by nearly 7 percent more than the increase in the hospital market basket--currently estimated to increase by about 5 percent in 1988. Thus, rebasing would result in a nearly 12 percent increase in hospital charges--or in the complete elimination of the net patient revenue operating margin.

CONCLUSION

Prospective pricing was a bold step to reform the system of hospital payment in an effort to create positive incentives to control costs. As originally designed it won the broad support of the hospital industry. An essential feature of that design was the opportunity to earn a surplus which was necessary if hospitals were to carry the risks inherent in prospective pricing, and which can be used to improve services to Medicare and non-Medicare patients alike.

If hospitals have been able to earn a surplus under the system, the system is working as it should. It will enable hospitals to continue providing high quality care to Medicare beneficiaries at the same time that the Medicare program has experienced the lowest rates of increase in expenditures since it was created. To rebase the system--or to ratchet down the prices because hospitals reported surpluses in the first year of the program--would fundamentally change the original design, violate the basic trust of providers in the good faith of the federal government, and threaten the future delivery of high quality health services to Medicare beneficiaries.

Much of the discussion of surpluses also misses a fundamental point. The most recent complete data on Medicare costs are from 1984. Enormous changes have occurred in utilization since then, and Medicare costs in 1988 are likely to bear little relationship to costs in 1984. Moreover, since 1984, prices have been rolled back substantially by Congress, leaving a 10 percentage point gap between the rate of increase in prices and the rate of increase in the hospital market basket. Any surpluses that may have been earned in 1984 have probably been eliminated. There are no actual Medicare data available for more recent periods, and data for all patients indicate that costs have continued to increase and operating margins have declined sharply.

Finally, in the discussion of Medicare "profits" there has been little attention given to the need of hospitals to earn a surplus, given the risks they are carrying under the prospective pricing system. Specifically, each DRG includes a significant number of high-cost patients who can completely wipe out the "profit" earned on large numbers of low-cost patients, and a hospital that earned a surplus one year may well incur a sizeable deficit the next. As originally set, the prices made no allowance for these risks. Hospitals have had to create this surplus by increasing their efficiency. It should not be taken away if their ability to continue providing high quality services to Medicare patients without relying on private-sector subsidies is to be preserved. An increasingly competitive private sector cannot and should not be expected to subsidize Medicare. Our common goal should be the development of a payment system that is fair, adequate and predictable, and that promotes the efficient delivery of high quality hospital care to the nation's elderly.

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Chairman STARK. Mr. Dauner?

## STATEMENT OF C. DUANE DAUNER, PRESIDENT, CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

Mr. DAUNER. Thank you, Mr. Chairman.

Members of the committee, I am with the California Hospital Association and am pleased to discuss with you some of the points made by Dr. McCarthy and others as they relate to California.

Probably a point that must be emphasized is that all of the costs incurred by hospitals are not recognized in the data that has been reported to you. For the last decade, the State of California has collected data from hospitals on a quarterly and annual basis, and they spread the cost of operating a hospital over the third-party payers. For all years except 1984 and 1985, Medicare has produced a negative margin in California. In 1984 it became positive, but in 1986 it was back to minus 2.59 percent.

Now, the reason is that it costs a lot more to operate a hospital than is recognized by Medicare. The biggest factor in California is uncompensated care, mainly people that are uninsured and underinsured or unable to pay, including a large alien population.

I distributed this morning a handout to you that was requested by Dr. Brian Biles. I would like to show you what would happen if an across-the-board reduction is made; in other words, rebasing.

Under the current system, 51 hospitals in California fall below the mean minus one standard deviation. Beyond the standard deviation indicates that it is significant. We have 51 hospitals out of a total of 540 in this category now.

If we increase the cuts by rebasing and save back 3 percent of that cut, which means you would reduce payments by 7 percent, you notice that the number of hospitals which drop below the mean minus one standard deviation is 144, or 27 percent of the hospitals.

And then, further, you will notice that 32 of those are rural. There are 81 rural hospitals in the State, thus the rural hospitals are disproportionately disadvantaged by any across-the-board cut. When a meat ax approach is taken, it is going to hurt the hospitals least able to handle reductions, such as the rural institutions and the disproportionate share providers.

On page 4 of the testimony, I would like to point out that there are a number of factors already in place that affect prices and the market. If we ask the marketplace to take care of the capacity of the system, as well as prices, then we need to do so in a way that allows the marketplace to function. But if we arbitrarily make across-the-board cuts, we put in a new market-control factor, and again, it does not equitably or fairly promote competition among the competitors. The ones least able to compete will be the ones that drop out of the system, and they may be the ones we need more than any other.

In California, nearly 24 percent of the patients in the State are enrolled in competitive medical plans of one type or the other, and so the forces in that part of the country, at least, are already at work and making the system efficient.

PPS, it has already been reported, has saved money, and I think that is self-evident.

Hospitals in California made a number of one- and two-time adjustments in 1984 and 1985 that we have documented, and I have summarized those on the top of page 5. The number of employees, the length of stay, the change in diagnostic procedures for inpatient admissions have been curtailed, and inpatients clearly have been shifted to less costly alternative settings.

Utilization review and peer review have had an impact, and the number of admissions has dropped. That is particularly significant for small or rural hospitals who have a small base to begin with; generally they have a larger number of Medicare patients than do other institutions.

There is distortion in any averaging system, and those distortions are magnified by additional cuts which are based on averages or across the board. I would urge you to reconsider making cuts which affect, "all hospitals the same", because all hospitals cannot absorb cuts in the same manner. The distortions that exist among hospitals are present because the cost of doing business is different in various parts of the country.

The time lag does create tunnel vision, and there is a problem in collecting data. California's data is reasonably accurate and current because it is required quarterly. Each hospital has 90 days after the quarter to submit the previous quarter's data, so that we have a relatively clear picture of what is happening. In the State, the operating margin is dropping significantly.

Finally, I would say, in response to questions asked of me before the hearing, what is happening in the way of hospital closures. Between 1979 and 1984, 12 hospitals closed in California. But in 1985, 10 closed, and in 1986, 7 ceased operation.

Now, the marketplace is working, and in the 2 years, 1984 and 1985, which was the second year of PPS, more hospitals closed, that is, the same number closed as in the previous 6 years. Something is happening in the behavior of hospitals.

Mr. DONNELLY. Can I just ask you, how many of those hospitals were State- or county-supported that closed?

Mr. DAUNER. None of those were State-supported institutions. I have excluded State-owned hospitals. These are community institutions. And of that number, one was a county-owned.

Mr. DONNELLY. Just one?

Mr. DAUNER. Just one, yes.

Mr. DONNELLY. And none city-owned?

Mr. DAUNER. That is correct.

Trauma centers in California are classified on a scale basis of level I, level II, and then two lower categories. In 1986, four of those ceased operating as a trauma center because of the financial pressures of operating the institution, and one additional trauma center closed in the month of February of this year. We expect two more to cease operation because it costs too much to operate these highly specialized services in light of issues related to quality of care and access to care. Rationing is going to be a result of cutbacks in third-party payments.

I urge the committee to consider major decisions that are general in nature that do not recognize what is happening in individual

communities. In rural areas, most hospitals are sole community providers, and they provide services less costly than transporting those patients to larger facilities. It is important for the infrastructure of our society to maintain those needed facilities.

Thank you.

[Statement of Mr. Dauner follows:]

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STATEMENT OF
CALIFORNIA ASSOCIATION OF HOSPITALS
AND HEALTH SYSTEMS
ON
MEDICARE OPERATING MARGINS
BEFORE THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
February 26, 1987

Mr. Chairman, members of the Committee, I am C. Duane Dauner, president of the California Association of Hospitals and Health Systems. We represent the hospitals in California and are pleased to appear before you today.

BACKGROUND

The American Hospital Association testimony reflects national data. My statement is based upon our experience in California which accounts for approximately 11 percent of Medicare hospital expenditures. There are 530 general and special acute hospitals in California, with 83,700 beds. In 1986, California hospitals provided care to 2.8 million inpatients and 23.5 million outpatients.

The subject of Medicare operating margins or profits has received considerable visibility because of reports from the Department of Health and Human Services (HHS), Inspector General (IG) and Congressional Budget Office (CBO). The Inspector General issued a report on the first year of experience under the Medicare prospective payment system (PPS) which stated that hospital Medicare profits ranged between 14 and 18 percent. Another report is due soon which is expected to show that hospital Medicare profits averaged 15 percent in 1985, the second year of PPS.

Profits are good, positive and necessary for hospitals to provide the high quality health care that consumers expect and demand. Any organization, whether for-profit or non-profit, needs to conduct business so that on a consistent basis income exceeds expense. Profits for hospitals are necessary to purchase new technology, maintain and update physical structures, provide new programs and services, and reduce borrowing which will in turn lower interest expense.

Congress and the Health Care Financing Administration (HCFA) have made several adjustments to the PPS program since its enactment in 1983, due, in part, to federal budget constraints and targets, ratcheting "improvements," and manipulations in the hospital market basket, case mix indexes and DRG weights. The following chart summarizes these actions:

**PPS ADJUSTMENTS TO**
**FEDERAL STANDARDIZED AND HOSPITAL-SPECIFIC AMOUNTS**

FY 1985 4.1 percent increase--budget neutrality mandate

FY 1986 October 1 - April 30 - rates "frozen"--HCFA action
March 1 - September 30 - 1 percent reduction--Required by Gramm-Rudman-Hollings Act
May 1 - September 30 - .5 percent increase--COBRA

FY 1987 1.15 percent increase--OBRA (Administration proposed .5 percent increase)

FY 1988 Market basket minus 2 percent--Required by OBRA

HHS and the Office of Management and Budget (OMB) are suggesting that more cuts in Medicare can be made through rebasing of the DRG rates. Such a move would exacerbate a worsening situation under the guise of reform and enhancements to the PPS.

The 1984 Medicare profits in California were reported by the IG to exceed 15 percent. Since the base for drawing this conclusion was the Medicare cost reports, several significant elements of cost were excluded, including:

- Charity care and bad debts relative to non-Medicare patients
- Malpractice costs on a proportionate basis
- Interest expense offsets
- PRO compliance costs
- Certain physician expenses
- Obstetrics and pediatrics
- Routine personal items such as radio, telephone, air conditioning and television when separately charged

These actual, legitimate costs were incurred but not recognized in the IG's calculations when determining profits. Thus, an inaccurate conclusion is drawn when compared to the total operating costs of hospitals.

California hospitals are required by law to submit detailed annual and quarterly reports to the Office of Statewide Health Planning and Development (OSHPD). Reports for the years 1982 through 1986 demonstrate that Medicare margins were negative prior to the advent of PPS. During 1984, the first year of the PPS transition, California hospitals improved their Medicare margin from -4.82 percent to 0.28 percent. Similar data for 1985 is not available because the State changed systems. Other data indicate that hospitals had a positive operating margin. However, in 1986 the picture turned bleak again. The Medicare operating margin dropped to -2.59 percent. Significantly, the overall operating margin from patient revenue fell from a 1984 high of 5.67 percent to 2.44 percent in 1986. These figures are shown in the following table:

PERCENT MEDIAN OPERATING MARGINS FOR 418 ACUTE CARE, SHORT TERM CALIFORNIA HOSPITALS

| | Patient Revenue and Expenses (Percent) | | | All Revenue and Expenses (1) (Percent) | | |
|---|---|---|---|---|---|---|
| | All Payers | Medicare | Medi-Cal | All Payers | Medicare | Medi-Cal |
| 1982 | 0.83 | -7.62 | -20.42 | 3.63 | -3.39 | -15.55 |
| 1983 | 1.28 | -9.25 | -27.17 | 4.08 | -5.68 | -24.95 |
| 1984 | 3.98 | -4.82 | -36.90 | 6.07 | -0.77 | -29.95 |
| 1984-PPS(2) | 5.67 | 0.28 | -40.03 | 7.23 | 1.05 | -32.52 |
| 1985 | 3.76 | N/A | N/A | N/A | N/A | N/A |
| 1986 | 2.44 | -2.59 | -39.98 | N/A | N/A | N/A |

Data Source: OSHPD Annual Cost Reports, 1982-1984
OSHPD Annual Quarterly Reports, January-September 1986

(1) Includes non-operating revenues (such as investment income, county and state appropriations) and expenses.

(2) 228 hospitals operating under PPS. Not all hospitals included in the 1984 entry operated under PPS because of their different fiscal years.

Medicare represents 37 percent of the patients, while Medi-Cal beneficiaries comprise 15 percent. Medicare losses are more significant because of the higher proportion of patients. Nevertheless, the severe underpayments by Medi-Cal since a federal waiver became operational in 1984 are threatening the survival of many hospitals, especially the rural, disproportionate share and safety net institutions of last or only resort.

Many rural hospitals have a high proportion of Medicare patients. The PPS fails to account for the unique circumstances surrounding these small, essential community facilities. The 21 percent differentiation in rates between rural and urban hospitals is not justified. More equitable treatment of these institutions, many of which are sole community providers, must be given or some will be forced to close.

Disproportionate share hospitals are similar to rural institutions. They are burdened with patients who are unable to pay, have fixed costs which cannot be shifted and are essential to the safety net. The PPS adjustment for disproportionate share providers is necessary; however, reducing payments for medical education to offset the adjustments will have the counterproductive result of damaging the physician training programs provided by many of these institutions.

Uncompensated care losses in California hospitals have been rising at an alarming rate. Between 1982 and 1986, these costs increased in excess of 75 percent. The following table outlines the increase in uncompensated care costs as a percentage of total hospital costs:

UNCOMPENSATED CARE AS PERCENTAGE OF HOSPITAL COSTS

| 1982 | 1983 | 1984 | 1985 | 1986 |
|---|---|---|---|---|
| 7.3 | 7.9 | 8.7 | 9.2 | 9.8 |

The PPS rates have not kept pace with increases in the hospital market basket, as summarized in the following table:

PERCENT INCREASE IN THE PROSPECTIVE PAYMENT RATES AND THE HOSPITAL MARKET BASKET

| Federal Fiscal Year | 1985 | 1986 | 1987 | 1988 | 1984-1988 |
|---|---|---|---|---|---|
| PPS Rates | 4.1 (1) | 0.5 (2) | 1.15 | 2.8 (3) | 8.8 (4) |
| Hospital Market Basket | 5.3 | 3.3 | 3.6 | 4.8 | 18.1 (4) |

Data Source: Federal Register, August 31, 1984; May 6, 1986; November 24, 1986.
Data Resources, Inc., Health Care Costs, vol. 6, nos. 7 and 11.

(1) The compound effect of raising PPS rates by 5.2 percent and reducing DRG weights across the board by 1.05 percent.
(2) Increase effective May 1, 1986 only. Rates were frozen between October 1, 1985 and April 30, 1986.
(3) Current legislation provides for an increase equal to the hospital market basket less two percent.
(4) Cumulative increase between 1984 and 1988.

Several facts about the operation of California hospitals should be mentioned. Marketplace forces and incentive payment plans dominate the private payment portion of hospitals' revenue. State legislation enacted in 1983 encouraged third-party payers to develop incentive-oriented contracts with hospitals. Nearly 24 percent of the population is enrolled in health maintenance organizations (HMOs) or competitive medical plans (CMPs). Today, 40 HMOs/CMPs and 66 preferred provider organizations (PPOs) are operational in California with several more in the developmental process. These payment plans have, in effect, substantially reduced the hospitals' ability to shift unreimbursed costs from Medicare patients to private third party payers.

IMPACT OF PPS

California hospitals have responded to governmental and private sector payment initiatives with unprecedented advancements. The rate of increase in hospital costs has dropped from 20 percent in the early 1980's to less than seven percent in 1986. Care is being delivered more efficiently and effectively. Alternatives to inpatient care are being expanded, even though inpatient utilization in California is well below the national average.

Hospitals made several one- or two-time adjustments in their operations during 1984 and 1985. Specifically, the number of employees dropped, length of stay was reduced, diagnostic procedures were curtailed, in-patients were shifted to the least expensive setting, utilization and peer review activities took on a new dimension of intensity, and the emphasis on capital expenditures was redirected to more efficient alternatives. These major changes cannot be repeated annually,

particularly in the face of an aging population, intensity of care and severity of illness, new technology, fewer inpatients and the cost of doing business in an economy which is not controlled by hospitals.

Hospitals have responded exactly as designed. They have made major strides and continually are becoming more competitive. Caution must be exercised, however. Our early successes will be short-lived unless the cost and utilization factors which transcend hospitals are considered by private third-parties and the government.

The federal government has benefitted from PPS. California hospitals have lost more than $4 billion in Medicare payments since PPS was initiated. The State has saved more than $1 billion under its Medi-Cal selective provider contracting program, according to a report released earlier this month by the California Medical Advisory Commission, the body which "negotiates" rates with hospitals. This $1 billion "savings" also has saved the federal government $1 billion in matching funds.

California hospitals are being hit with unfair, multiple losses under Medicare PPS. Beyond the inadequate adjustments in PPS rates, redistribution of payments under the national and regional payment formula is penalizing hospitals in California and a few other states while producing windfall gains to hospitals in lower cost states. The cost of doing business in California exceeds the national average. Construction costs, for example, are 31 percent higher than the national average. The adjusted gross area wage index alleviated the distortion in payments for employees' costs, but inequities due to nation-wide average payments for non-wage costs, intensity and severity have not been dealt with by HCFA.

FUTURE CONSEQUENCES

Any risk-oriented system, to be successful over the long term, must produce a positive margin or the system will fail. No business can continue to operate while losing money every year. Without a strong bottom line, the hospitals' options in a buyers market are sobering: restrict access, ration care, reduce quality, eliminate services, allow facilities and services to deteriorate, fail to keep and maintain modern technology, close or hang on until bankruptcy is necessary.

The consequences of underpayments, whether by inadequate rates or distortions due to national average rates, will affect patients. Both of these issues must be addressed now. If we retain a regressive PPS and compound those deficiencies by basing projections for future years on a flawed system, the damage to patients will be irreparable.

SUMMARY

To understand the meaning of Medicare operating margins or profits, the basis of such calculations must be defined. HHS and the IG use a base which does not account for actual hospital costs nor for all of the legitimate differences in the cost of doing business among different areas of the country. Medicare PPS must be revised to overcome these inherent faults.

The Medicare operating margins or profits from 1984 and 1985 do not accurately reflect previous and current experience in California hospitals. Strategies of hospitals in the competitive marketplace have achieved savings for the government as well as the private sector. The operating margins of the first two years of Medicare have fallen. California hospitals experienced a Medicare operating deficit of -2.59 percent in 1986 according to OSHPD.

The California Association of Hospitals and Health Systems recommends that atypical Medicare operating margins during the first two years of PPS be taken in context of the hospitals' environment and overall economy, that the flaws of PPS be corrected and that annual PPS rate adjustments be reasonable and adequate based upon changes in the hospital market basket.

We appreciate the opportunity to present this statement to the Committee.

Chairman STARK. Duane, wasn't most of the financial impact, though, in California the Medicaid cuts, what we call Medi-Cal? We had a big cutback there which really is not germane to this.

Mr. DAUNER. That is correct. If you would look on page 3, in terms of percentage, the Medi-Cal cutbacks have been more significant by far. However, 37 percent of the patients are Medicare and 15 percent are Medi-Cal, so that a 1 percent cutback in Medicare has nearly three times the impact as the same percentage cutback in Medi-Cal, but Medi-Cal is grossly underpaying——

Chairman STARK. For my colleagues, that is what we call Medicaid in California, just to get everybody on the same wavelength. Thank you very much.

Mr. Newman?

**STATEMENT OF HOWARD N. NEWMAN, FORMER ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, AND PARTNER, POWELL, GOLDSTEIN, FRAZER & MURPHY**

Mr. NEWMAN. Mr. Chairman, I think I was invited to join this panel because of past sins. I, as you may know, was the administrator of the Health Care Financing Administration, if my memory serves me correctly, until about noon on January 20, 1981. [Laughter.]

Mr. LEVIN. What happened then?

Mr. NEWMAN. The people spoke. [Laughter.]

I also have, earlier in my life, served as the president of an academic medical center, and as a result of some of those things, I am here today, different than my colleagues at the table, not representing any institutional point of view. I have the luxury of just expressing my own views, which are offered in the written testimony.

What I would like to do briefly, in response to your request for brevity, is just comment on two of the points that were made in the earlier discussion. Mr. Pickle, as I recall, indicated that, in his view, the system seems to be working as it was intended to work, and I agree with that.

I have looked at the data that has been presented this morning, and it seems to me that they all are saying essentially the same thing, and that is that PPS has produced relatively healthy profit margins, and I think that is okay. I think that is what was intended.

On the other hand, to me, there is something worrisome about what is happening in the health care financing world, but it is not profit margins in PPS. I think that by defining Federal health policy exclusively in budgetary terms, we forfeit the opportunity to relate health financing means to programmatic health policy ends. The question is not whether we are spending too much but, rather, whether we are getting our money's worth.

It is, in my view, not enough for the Federal Government to declare itself a prudent buyer and hope for a set of socially desirable outcomes. If we beiieve in financial incentives, why don't we provide incentives to reduce infant mortality, as an example?

So I think, with all due respect to the purpose of the hearing today, the profit margin issue really needs to be seen in some broader context, as some of the earlier discussion indicated.

The other point I just would like to address briefly is the point that Mr. Gradison made about the historic trust that existed among these parties. I think it is correct to say that, in an earlier day, we expected the hospital, particularly the nonprofit community hospital, to perform the cross-subsidization function that was alluded to earlier, that we gave them an implied license to charge some people more than the cost so that they could serve some people who could not pay the cost.

We have now changed that equation. We have said—and, as far as I am concerned, unfortunately have said—with the Federal Government in the lead, our only responsibility is to be a prudent buyer. All we want to do is pay as little as possible. And if everybody is a prudent buyer, it seems to me you leave the hospital in a position where it cannot cross-subsidize.

Now, there is nothing particularly dramatic about that conclusion, except it seems to me that if we take away the capacity of the hospitals to cross-subsidize, let's also take away the expectation that they are going to be able to provide those services with resources that are not available to them.

If the Federal Government abandons any obligation with regard to these important social objectives, if the hospital does not have the capacity to provide that service, what are we left with? Well, it is either States, which I think history will show respond with great variation, unacceptable variation in many respects, or a system which will be free to abandon socially desirable objectives which are inconsistent with profit maximization.

Now, I, for one, am unprepared to let the Federal Government opt out of this equation. At the very least, it must be held to account for the consequences of its disinterest.

Thank you.

[Statement of Mr. Newman follows:]

STATEMENT OF

HOWARD N. NEWMAN

FORMER ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

PRESENTED TO THE HEALTH SUBCOMMITTEE

HOUSE WAYS AND MEANS COMMITTEE

FEBRUARY 26, 1987

Mr. Chairman and Members of the Subcommittee, I am honored to come before you this morning. My name is Howard Newman and I am a Partner in the law firm of Powell, Goldstein, Frazer & Murphy. I also currently serve as a director of a local hospital and am Chairman of the National Capital Area Health Care Coalition. I have spent a substantial portion of my career as a health care administrator in several academic medical centers including a period of six years of service as the first President of the Dartmouth Hitchcock Medical Center and in the federal government as Commissioner of the Medical Services Administration (Medicaid) and as Administrator of the Health Care Financing Administration.

I was invited to join this panel by the American Hospital Association but should point out that the Association bears no responsibility for the opinions expressed in my testimony.

I. The Current Profit Margin Debate

I have recently had some chance to review material regarding hospital profit margins on Medicare patients under the Prospective Payment System (PPS) published by Congressional Budget Office staff, the Prospective Payment Commission (ProPAC), and the American Hospital Association (AHA). There have also been a number of reports in the trade press over the past few weeks on this topic, discussing these materials, predicting the content of the soon to be issued report of the Inspector General and the recently issued CBO report.

This flurry of interest in hospital profit margins is due to the fact that, for the first time, actual data from cost reports submitted during a PPS year are available for comparison with the PPS rates which have been calculated from trended 1981 data. According to these reports, hospitals' average profit margin on Medicare patients under PPS during fiscal year ending 1984 was in the 12-14% range. The data also suggest that the distribution of hospitals around this average may be quite wide, with some hospitals losing significant money on PPS patients, and other hospitals earning significant profits on PPS patients.

These materials and articles also set forth arguments and counter-arguments surrounding the profit margin issue. Some groups and commentators have suggested that the 1984 margins represent a one-time effect, reflecting efficiencies which were instituted in response to the PPS system but which cannot be repeated (such as reallocation of personnel or equipment, new treatment approval procedures, and the like). During fiscal year 1984, many hospitals had not yet chosen the computer system they would use for cost reporting, billings, and purchasing under PPS; many hospitals had been paid under the PPS system for less than a year at the time the data we are analyzing was collected. Another argument heard is that the 1984 margins are, at least in part, based on reporting artifacts, not true profits. For example, some suggest that 1984 cost reports are not a reliable indicator of actual costs, now that those reports are not the basis for a majority of hospitals' Medicare reimbursement. For

reasons such as these, many have suggested that it is inappropriate to use this 1984 data as the basis for significant changes to the PPS system.

As part of this debate over the meaning of the apparent 1984 PPS profit margins, the American Hospital Association has indicated that its more recent data show a strong downward trend in overall hospital profit margins over the past three years. It is, in fact, reasonable to expect current margins to be lower than 1984 margins, because Congress has limited PPS price increases since 1984 to rates below the hospital market basket inflation rates. For this reason, it has been suggested that it would be inaccurate to use the 1984 margins trended forward as a proxy for current PPS profit margins. The AHA data show margins in the 3-5% range for recent years.

The debate over PPS profit margins has not been limited to discussion over the meaning of the 1984 data; the implications of having created an incentive-based system are also an important part of these discussions. PPS was intended to place hospitals at risk, and thereby create incentives for cost-effective treatment of Medicare inpatients. Hospital groups now point out that profits are necessary to make an incentive-based system work. If a hospital is expected to play in a risk-based system, profits are necessary to cover the risks inherent in that system. The possibility of sustaining losses for reasons not within the hospital's control (such as a case mix with unusually high severity of illness) creates the need for surplus as insurance against loss. Hospitals must budget against loss over several years; one year's profit margin is not an accurate indicator of the appropriateness of a surplus level. If one hospital achieves above average PPS margins in one year, and then is a net loser under PPS during the next year, perhaps the system is working appropriately. It may be unrealistic to judge the System on the basis of the outcome during only a single year.

Finally, the data being discussed also suggest that the PPS created a distribution problem. There is some indication that profit margins are not equally distributed, but vary between hospitals according to number of beds, geographic location, and perhaps other identifiable factors. I will return to this question below, but it bears mention here that the presence of distribution effects suggest that an across-the-board response to perceived excessive margins would be inappropriate; a more targeted approach may be indicated.

Having reviewed some of the major arguments we are hearing in the profit margin debate, I shall leave to others to discuss the technical arguments about whose methodology more closely approximates the true measure of hospital profit margins under PPS. What all of the studies seem to agree on is that for most hospitals PPS has produced healthy profit margins. It is my view that, while there is something very worrisome about what is happening in health care finance today, it is not that there are profit margins under PPS.

II. Budget Policy Instead of Health Policy

What does trouble me is that, by defining federal health policy exclusively in budgetary terms, we forfeit the opportunity to relate health financing means to programmatic health policy ends. The question is not whether we are spending too much, but rather are we getting our money's worth. It is my view that it is not enough for the federal government to declare itself a prudent buyer of medical services and hope for a set of socially desirable outcomes. If we believe in financial incentives, then we should provide incentives to accomplish programmatic, and not merely fiscal, goals. How about providing incentives to reduce infant mortality in our inner cities, for example.

III. Hospitals Can Be Expected to Act Rationally

As one who has spent nearly thirty years as a participant or interested observer of the hospital field, it is my view that hospitals always behave rationally given the economic and political circumstances in which they find themselves. Thus, under a cost reimbursement system with limits on payment for routine services, as many costs as possible will be moved out from under the "223" limits; and in a prospective payment system determined by DRGs, a great deal of attention will be paid to coding and case mix classification. Profit margins are a natural and rational response to a fixed price payment system.

Historically, through what might be thought of as a social contract, the hospital, particularly the voluntary (private, non-profit) community hospital, has been provided with an implied license to cross-subsidize services from those who can afford to pay more than the cost to those who cannot afford to pay, in exchange for the hospital's promise to extract no private inurement to its owners.

If we remove the hospital's implicit license to cross-subsidize between paying and nonpaying patients, should we not also remove the expectation that the hospital will be the instrument through which we achieve such socially desirable goals as that of providing reasonable access to care without regard to financial circumstances. If we allow the federal government to disclaim responsibility, and at the same time remove the means to do so from the hospital, we are left with either the tremendous variability resulting from state and locally initiated efforts unguided by any expression of national standards, or a system which will be free to abandon socially desirable objectives which are inconsistent with profit maximization. I, for one, am unprepared to let the federal government opt out of this equation. At the very least, it must be held accountable for the consequences of its disinterest.

IV. The Special Needs of "Disproportionate Share" Institutions

As this issue of "Medicare profits" continues to be debated this year, it is important for the Committee to continue to recognize that there is, at the core of our health system, a relatively small group of hospitals whose role and needs are substantially different from the rest of the industry. These are the most "disproportionate" of the "disproportionate share" hospitals, who generally receive significant direct state and local appropriations to help finance the major indigent care and public health services they provide.

In our nation's metropolitan areas, many such hospitals, because they are also major teaching hospitals, may also be found to have positive Medicare margins by the methodology adopted in the studies being presented to you today. But as this Committee has clearly recognized in the past, the mission and patient population of such hospitals virtually guarantee that their overall margins will be far lower than their private sector counterparts.

A recent survey by one organization representing such hospitals, the National Association of Public Hospitals, found that, on average, 60% of its member hospitals' revenues were derived from Medicaid and direct state or local appropriations. Medicare represents on average only 19% of their revenues, far smaller than the national average, but important nevertheless, since all private third party payors combined account for just 11% by comparison.



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Because of this patient mix, and the range of special services required to serve this population, many such hospitals operate at a loss, even after "Medicare profit" and state and local subsidies are taken into account. A recent AHA/Urban Institute study has found, for example, that almost 50% of public hospitals in the nation's 100 largest cities experienced gross revenue deficits in 1982, as compared with just 22% of nonprofits. Moreover, the negative margin for public providers was over five times greater than that of nonprofit hospitals experiencing deficits. Data recently collected for 1984 appears preliminarly to show similar results. Clearly, the Committee's past vigilance in protecting this important group of hospitals must be continued in the future.

V. Some Unintended Consequences of PPS

Reduction in services provided to those who cannot pay, and in the overall range of services provided to all patients by disproportionate share institutions, are only two of the many consequences of eliminating the ability of hospitals to attend to objectives other than economic efficiency. Some hospitals, for example, have already decided simply to eliminate certain services from their institution. A decision to discontinue a service based, not on absence of community need for that service, but on fiscal efficiency grounds alone, will certainly adversely impact the quality of care that institution can offer. Indeed, quality of hospital care has recently become an important issue in its own right. We are in danger of finding that quality of care has been adversely affected as an unintended consequence of a purely budget driven decision making process. 1/

Much of the initial debate over PPS, as well as the discussion of PPS margins in which we are currently engaged, falls back on the assumption that a high PPS profit margin is an indication of efficient delivery of services. Yet, more and more evidence shows that PPS margins are in large part due to factors unrelated to economic efficiency. For example, we now have evidence that hospitals located near, but not in, large metropolitan areas can take advantage of higher wage indices while actually incurring lower employee compensation costs. These institutions may, due to their suburban location, enjoy a

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1/ In pursuit of economic efficiency, we can also expect hospitals to exert tight controls over the resources devoted to Medicare inpatient stays, for example, by limiting Medicare patients' access to certain services where there is a high risk that the cost of the services will not be fully covered by the DRG price. Stated more bluntly, it is reasonable to expect hospitals to begin rationing services to beneficiaries, according to their individual cost experience with DRGs, and not according to a strategic long-term plan to increase overall quality.

It will be important to bear in mind as this debate continues that maintaining quality of care is not accomplished by maintaining past medical practice patterns. Innovation, not just in technologies, but in personnel utilization and other practice patterns are an important part of quality control, and reimbursement rates must allow room for the experimentation which inevitably preceeds such innovation.

For example, a too tightly controlled PPS system may deter introduction of new technologies or services which require high initial cash outlay, even though the new service may increase long-term efficiency and productivity at the hospital.

healthy PPS profit margin, but it cannot be said that they are more efficient than their inner-city or rural counterparts. Similarly, the surest means to a good PPS margin is to have a low-severity case mix. Is a profitable case mix a true measure of efficiency? Of course not. Yet, that is what much of this debate implies. A hospital's PPS margin could be improved by simply discontinuing medically necessary programs, an action which is not efficient, but which is increasingly being encouraged by the PPS incentive structure. We have to ask why the winners are winning, and why the losers are losing under PPS.2/

VI. Concluding Remarks

Today we find ourselves gradually, but inexorably, moving to the point where, without an explicit subsidy, the hospital can only serve those who can pay its price -- for that is the rational thing to do in a world of prudent buyers.

Actions of the federal government invariably have enormous impact on our health care system. Inaction can have similar consequences. Personally, I share the view of the late Patricia Roberts Harris, that government's highest responsibility is to care for the vulnerable among us who cannot provide for themselves in a competitive environment.

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2/ Another objective for the prospective payment system was to increase the predictability of Medicare payments, both for the hospital and the federal government. From the hospitals' perspective, predictability was considered important because, as hospitals were increasingly being asked to behave as any other economically rational actor in a competitive economic system, strategic long-term planning was becoming essential.

Are we making progress toward this goal? Clearly not. Since the enactment of PPS, each budget year has seen an annual legislative battle over rates of increase and other issues, making the hospitals' budget process uncertain at best. In addition, it is clear that hospitals have been caught in the middle of political battles between HHS and Congress. And now, less than four years since the system was set in motion, Congress is considering making alterations in the system which would cause drastic changes in reimbursement levels.

Chairman STARK. Thank you.

Mr. Gradison?

Mr. GRADISON. Mr. Chairman, I would just like to make a comment, because there is something that, at least if it has been said, I missed this morning.

There are in our economy some signals with regard to what people anticipate will happen in the future. It does not mean they are right, but they might be worth examining. One is the stock market, and other is the bond markets.

The message that I seem to be reading today in the face of a booming overall stock market is that hospitals are not a very good place to have your money right now. Now, that has nothing to do with 1984 or 1985; it has to do with a view of the future. It does not mean it is correct, but I think it is something interesting to think about.

The second thing is the flow of capital into new hospital construction. It has reduced substantially. The credit rating of hospital bonds in many instances has been changed downward. That has been the pattern.

I only mention that not to try to draw any conclusions but just to reemphasize a point I said earlier. I think we have to think about what may be happening out there, and I have been involved in securities markets all my life, and I know they are not always correct. But, in an instance like this, where stock prices are going north but health industry stock prices are going south, I think it may be worth just reflecting a little bit on drawing individual conclusions as to what that may mean.

Chairman STARK. Mr. Donnelly?

Mr. DONNELLY. Thank you, Mr. Chairman.

All of these different statistics and different conclusions tend to boggle the mind.

Let me just ask one question of Dr. McCarthy. In response to a question from my colleague, Dr. Altman was somewhat critical of using regions as a basis for statistical analysis of operating margins. Would you agree with that, that it would be a more appropriate vehicle to look at statistics State by State?

Ms. MCCARTHY. There are great variations even when you go State by State. So much of a hospital's fortunes, whether it be directly under the Medicare program, Mr. Donnelly, or in treating patients whoever pays, has to do with the structure of the hospital, the people it treats, what is the payer mix that it treats, the amount of uncompensated care that it has, the access it has or does not have to some philanthropic resources to help support it, and the intensity of the services that it provides compared to someone else.

While we see some patterns based on size and some patterns based on rural versus urban that are largely attributable to the formula we have used in the DRG system itself, you still must analyze on a hospital-by-hospital basis before you can say why it is that one urban hospital is not in as poor shape as another, or why one teaching hospital has a net margin of minus 5 percent and another one of 1.2 percent.

So I would agree that regions per se are not good, nor are States per se. There is a great deal of variation within a State. Rural or

urban, size, teaching-nonteaching status give you a little bit better view, but a hospital is not a hospital is not a hospital.

Mr. DONNELLY. I would like to ask Mr. Dauner, you mentioned the number of hospitals that closed in California. Were they all nonprofits, or were some of them for-profits?

Mr. DAUNER. One of them was a for-profit; the remainder were not-for-profit except for the one county.

Mr. DONNELLY. And how many beds were included in the bulk of the closures, and what percentage would that be to the total number of beds in California? If you don't have that, obviously, off the top of your head, I would appreciate if you could get it.

Mr. DAUNER. There are 87,000 acute beds in California.

Mr. DONNELLY. Oh, you do have it? All right.

Mr. DAUNER. The exact number that closed I do not have, but I do know that most of them were small, and I think with only two exceptions they were all under 100 beds. I can get you the exact numbers if you would like.

Mr. DONNELLY. All right.

[The information follows:]

Spread of Margins
California Hospitals
1986

Median: - 2.59%

Mean: - 3.50%

Standard Deviation: 15.3

51 hospitals below Mean minus one Standard Deviation

If Medicare DRG rates are rebased to reduce payments by 7%, 144 hospitals will be below the Mean minus one Standard Deviation.

Summary - Hospitals Below Mean Minus One Standard Deviation

| | Currently | With 7% Reduction in Payment |
|---|---|---|
| Number of Hospitals | 51 | 144 |
| Rural | 13 | 32 |
| Urban | 38 | 112 |
| Non-profit | 22 | 85 |
| For-profit | 12 | 30 |
| County | 8 | 9 |
| District | 9 | 20 |

Source: California OSHPD Annual Quarterly Reports, January-September, 1986
CAHHS

February 26, 1987

Chairman STARK. Close to 1,000 beds.

Ms. MCCARTHY. Mr. Donnelly, if I may add, in 1985, across the United States, there were 81 hospital closures, 47 not-for-profit, 12 public, and 22 proprietary.

Chairman STARK. Did the occupancy rate go up or down in the same year, total?

Ms. MCCARTHY. The total occupancy rate last year was approximately 64 percent nationwide.

Chairman STARK. So it went down?

Ms. MCCARTHY. It was down slightly, very slightly.

Chairman STARK. So you closed the hospitals, but the occupancy rate still dropped?

Ms. MCCARTHY. Well, many of the hospitals operating today, as you know, have banked beds so that they are out; they have been out for some time; we are not paying for them on a day-to-day variable-cost basis.

Mr. DONNELLY. One final question for Dr. McCarthy. You seem to have more current data in your organization than what is available to everybody else. Have you done an analysis of what the President's recommendations on capital and on teaching hospital reimbursement would they do to the margins, by region or nationwide if they were adopted?

Ms. MCCARTHY. No, sir, we have not completed it. We are working on the impact of the administration's proposed changes, but I would be pleased to get the information to you when we have it.

Mr. DONNELLY. Are you doing it State by State, or are you doing it by region, or how are you doing it?

Ms. MCCARTHY. We are doing it on a sample basis, and again, a much better stratified sample than we have with the 1985 profit figures, but it is a sample basis, and therefore, it is very hard to do it State by State.

Mr. DONNELLY. Let me just leave it there, Mr. Chairman.

Chairman STARK. Mr. Coyne?

Mr. COYNE. Thank you, Mr. Chairman.

First of all, I think the hospitals are to be congratulated on the reduction in costs and the increase in the amounts of margins that we are experiencing, but I wonder if there is any evidence that indicates that it comes as a result of shifting care to outpatient services and clinics.

Ms. MCCARTHY. A part of the hospital cost reductions are due to in fact a decrease in the number of full-time equivalents. They are due to the substitution of less costly personnel for more costly personnel. They are due to the discontinuation of less essential services. They are due to some very hard bargaining and negotiating and group purchasing for nonlabor resources, and they are due to in fact treating the patient in the least costly setting possible. At times that is an outpatient setting; at times it is actually the home. But it is a combination.

Mr. COYNE. But those two factors certainly enter into the reduction of costs?

Ms. MCCARTHY. Yes, they are a part of the inpatient cost reductions.

Mr. COYNE. Thank you.

Mr. PICKLE. Mr. Chairman?

Chairman STARK. Mr. Pickle?

Mr. PICKLE. Earlier, I had asked the previous panel, if we did enter into a rebasing, could that affect the quality of care or the efficiency of the hospital? I would like any of you to comment on that issue.

Let me just pose one or two other questions because I have an appointment and I have got to leave the committee. If we were to rebase and thus cut down the charge level, would this negatively impact those hospitals that are already losing money now; that is, weak hospitals? How much so, and how many of them might be affected?

Now, having asked that, it just seems to me that we may want the committee to consider the new figures that are coming out. We are really looking only at 1984 figures, and only with respect to Medicare, and you are looking at a broader approach than just Medicare. You are looking about nonprofit costs and other things, so I think that is a factor.

The only other observation I make is that, as we look at this question, I hope we don't consider it just as a budgetary question, because that is the temptation. But I don't think hospitals, either, should assume that we are not going to effect anything, because it may well be in order to look at a redefinition of rebasing or adjustment or a new calculation of it in some respects. So I don't think we say we are going to let you alone, but I think we ought to proceed carefully.

Now, would any of you want to comment with respect to either the efficiency, the quality of care, and/or the smaller hospitals? The ones that are losing now, how would they be affected?

Ms. MCCARTHY. Let me first try, and then I will turn it over to my colleagues. First of all, to remake a point that is very important in the profit data from 1984—hospitals realized surpluses. It is doubtful that the surpluses are quite as high as those reported, but they realized them.

Since then, hospitals have received payments that were payment increases equal to only half of the increases in the actual market basket, so that if we had——

Chairman STARK. How do they relate to their costs, though?

Ms. MCCARTHY. If we assume that, when we went in, we were paying costs and we set a price, and we then said, as Mr. Cohen did this morning——

Chairman STARK. I am not sure that is a valid assumption, but go ahead.

Ms. MCCARTHY. Well, as Mr. Cohen said this morning, the most rigorous regulatory systems say pay for the market basket plus a factor for technology. We have not only seen no market basket plus a factor for technology; we have only seen a less than 9-percent increase since the program began.

So, if we start there, we show that if you rebase, 43 percent of all hospitals will have deficits.

Mr. GRADISON. Overall, or just on the Medicare business?

Ms. MCCARTHY. Overall, and if you rebase, 22 percent of those will have deficits greater than 10 percent. That cannot help but impact quality. It absolutely cannot help but impact quality, and the issue of whether those that are now in a fine line would be out

of business, I think, is almost a moot question. They would be, if not out of business, hard-pressed to deliver the kind of service you would want delivered to Medicare beneficiaries.

Mr. NEWMAN. Can I just express an endorsement of the earlier view that Stu Altman offered on the dangers of sort of across-the-board rebasing action? My reason may not be everybody else's, but I am concerned that there is an assumption about a correlation here in all these discussions between efficiency and profitability.

I am not sure that there is not an element of this system which is sort of unrelated to all of the good things that Dr. McCarthy indicated hospitals have been doing. If a hospital reduces FTE's, group purchases, will they in fact become more profitable given the vagaries of the DRG system? So I think caution is a byword here.

Mr. PICKLE. What if we were to have a rebasing across the board? Under present regulation, would the authority to make that rebasing be given to HCFA, unless we change it otherwise, to carry it out? Isn't that a rather sobering contemplation? [Laughter.]

Mr. NEWMAN. Well, as of noon on January 20, 1981, I will not comment. [Laughter.]

Mr. PICKLE. Thank you, Mr. Chairman.

Chairman STARK. Mr. Moody?

Mr. MOODY. Thank you.

I would like to react first to the testimony by Dr. McCarthy.

Dr. McCarthy you make a point that the hospitals are at risk because some patients are far more ill than the average. But isn't that variance supposed to be included? It is a mean; it is an average. It is supposed to include patients on both sides. You are also at risk that some patients will come in far less sick. I mean, if the DRG's are correctly calculated, I don't understand——

Ms. MCCARTHY. They are an average price, and as with any average price, then you just have to hope you are the patient-taker, the hospital that is receiving a greater number of those patients that fall below the average in the resources they require.

If you just happen to be the reverse, you had better have a cushion because the price will not cover the cost. And you are right; the chance is there because it is an average. But that is average across the industry now, not average within a particular patient facility. That is why that surplus margin is essential for operations.

Because the kinds of patients you see can in fact shift from year to year, your experience in 1 year may not prove to be your experience in the second.

Mr. MOODY. Right, but the at-risk is a necessary component as well to keep the costs down.

Ms. MCCARTHY. Yes.

Mr. MOODY. But that is not a criticism that they are at risk.

Ms. MCCARTHY. No, no.

Mr. MOODY. I guess I read your testimony to imply that there is an at-risk problem here. I think we all would agree, that is precisely an at-risk component that we need, to get the results we want.

Ms. MCCARTHY. The only point I was attempting to make—and obviously I did not make it well in the written testimony—was that usually when we talk about people going at risk, we are talking about them being at risk with matters that are totally within their control: how efficient are you? And the point I was simply trying to

make was that, in the PPS system that we have designed, we are asking that, but we are also putting people at risk for things that are totally beyond their control, namely the type of patient that comes to the door.

Mr. MOODY. Right. Do you agree that there has been DRG creep that has pushed the other way, and has made the taxpayer more at risk by the overall change in the mix?

Ms. MCCARTHY. We do not accept the CBO assumption, for example, that you ought to artificially inflate hospital revenues by 4.5 percent to offset DRG creep. The PRO's are in place. The PRO's have the responsibility for reviewing patient care and for a fact validating that the appropriate case mix is assigned.

What we do see in hospitals——

Chairman STARK. If you would yield there, though, as I recall Dr. Gordon's testimony, I believe, it was not to suggest that the hospitals were being inappropriate; it is just that they learned to do it properly and that the creep was—there was nothing pejorative in that statement. It was just that the hospitals learned to obey the rules and got a lot of extra money for which——

Ms. MCCARTHY. Well, again, we have to assume that—I did not mean in my response to be the least bit in a defensive posture. My point was simply that a hospital was being paid for the DRG appropriately assigned and validated by the PRO, which had a price.

The second point was that the increase in the DRG case mix index was to be expected. We have treated patients who could possibly be treated on an outpatient basis, on the outpatient basis, and we have the most ill patients in the house, and in fact the DRG increase is attributable to treating patients who are more ill.

Mr. MOODY. Right, but this diagnostic creep, if it exists, is actually appropriate because now hospitals have an incentive to diagnose correctly. On a retrospective payment basis, they have no strong incentive, since the cost would be covered whether or not the diagnostic mix was accurate. So isn't this a positive development?

Ms. MCCARTHY. I think that it is positive to treat patients in the correct setting, and I think that is in fact what is happening. We are treating the most ill within the inpatient setting, and as a result, we are seeing an increase in the DRG case mix index.

Mr. MOODY. Right.

Ms. MCCARTHY. I think that is predictable and appropriate.

Mr. MOODY. Let me ask you another question that is related. I have heard it said by doctors in my district that one of the problems with the DRG's—one of the biases in the whole DRG structure—is that doctors are paid more for procedures than for thinking. They are paid more to intervene, surgically or in other ways, than they are for introspection or for using their human capital in ways that do not involve, quote, procedures, unquote. Would you comment on that? Do you also think the DRG's might need realigning at some point? This is aside from the question of risk. Let's assume it is revenue-neutral and is merely a realignment.

Ms. MCCARTHY. We are not including physician payments within the DRG rates. The issue of whether Medicare payments to physicians recognize more the technology-intensive diagnoses than they do the cognitive-intensive diagnoses I think has been shown to be true in a number of studies.

Mr. MOODY. Right. Do you have any comment on the RAP problem and the administration proposal to include them in the DRG?

Ms. MCCARTHY. We do not favor the proposal for two reasons. The first is that it puts the hospital in the middle. If in fact the governmental payments are ratcheted back for physicians, it puts the hospital in the middle when the hospital has not the responsibility for the decision that was made.

But an even greater concern as we watch the declining revenue margins in hospitals in 1986 is that we will spread an inadequate payment system further, and we really would not like to be in the position of a middleman in that instance.

Mr. MOODY. Right. Your testimony indicates that there is cross-subsidization. I can infer that from your statement. Am I correctly inferring that from your testimony?

Ms. MCCARTHY. My testimony speaks to cross-subsidization by the non-Medicare patient of the government patient that has taken place for a long period of time, yes.

Mr. MOODY. You're saying that the private pay is subsidizing the Medicare pay?

Ms. MCCARTHY. We have used the private payer to help defray the cost of uncompensated care. We have used the private payer to help pay costs that government payment programs do not deem to be allowable.

Mr. MOODY. Assuming that that happened in 1984, how does that statement reconcile with the alleged profit margins or operating margins of 1984? How do you square those two statements?

Ms. MCCARTHY. I do not have data on the hospital margins by payer, and I think the data that we do have and that we are looking at is again only as good as the assumptions that went into it. It suggests that there has been, for certain hospitals, a good experience under the Medicare program. It does not accurately reflect whether those hospitals had a higher cost than was put on a cost report for caring for the Medicare patient.

I do not have the data on the particular hospitals' other margins to know the extent to which, in 1984, they received more revenue from Medicare than they received from other payers. In certain instances, I imagine it is true.

Mr. MOODY. Well, the reason I said that is because your testimony uses the overall results to infer what has happened to the Medicare part. You obviously perceive a quantitative relationship between those two. So I assume you have made those calculations.

Ms. MCCARTHY. Because there really are no very reliable data at all on hospital revenue margins by payer, what we try to do is this: We do have margin data on hospitals per se, so that if you then try to work your way back looking at what proportion of the total hospital's business is due to treating a Medicare patient or patients, you could then make some assessment as to whether that 14 percent, 12, 15, whatever figure you use for the profit margin, is a good figure. And doing that, the math just does not work. So it suggests that there are surpluses, but they are not as high as those that are suggested.

Mr. MOODY. In your testimony, at page 6, the overall performance indicates that the surpluses are far lower than the Medicare component. This would imply that there is cross-subsidization going

the other way from what you suggest; namely, that Medicare is in fact cross-subsidizing non-Medicare. I am having trouble squaring your testimony.

Ms. McCarthy. In certain facilities, I believe that that could have been the case in fiscal year 1984; that in that year their Medicare payments were greater than their Medicare costs. By how much, I don't know, because we do not have—and it is recognized that we do not have—a very good way of cost-finding by payer.

But do I believe that happened in certain facilities in 1984? Yes, sir, I do.

Mr. Moody. Well, it seems it happened in the aggregate if these numbers that you provided are correct, and it is an interesting reversal from what we have been led to believe in other places.

Finally, you stated that rebasing would have an impact on quality. I think we all recognize that. Would that be, in your judgment, an absolute bar to rebasing?

Ms. McCarthy. I think rebasing would be a serious mistake. I believe that the Government, through its payment policies on the update factor, has in fact recouped any additional payments it may have made from the way it based DRG payments initially in 1981.

I believe that, if you had the data and could look at it on the margins today, you would be very concerned. I believe our focus ought to be the future. I think you care about the hospital's overall financial health because, if it is ill, it cannot serve any patient.

Mr. Moody. Right.

Ms. McCarthy. And I do not think rebasing is an intelligent public policy move.

Mr. Moody. But the flip side of what you are saying, I gather, is that the "savings," that have been obtained to date have not yet had an impact on quality.

Ms. McCarthy. We do not have any indication of a significant decline in quality. What we do find is less than 1 percent of cases which raise a question, and among those 1 percent, there are negligible quality issues.

Does that mean that, if you forced 4 out of 10 hospitals in the United States into an operating deficit position, that you might not be running a risk you would not want to run?

Mr. Moody. No. Thank you very much. That is interesting.

Chairman Stark. Mr. Donnelly, you had a comment?

Mr. Donnelly. This would have been a more appropriate question for panel I. We are about ready to spend billions of dollars to cover catastrophic illness for the elderly, and obviously, some of those savings will come from Medicaid, but the hospitals, up until this point, had to each have a percentage of that cost in bad debt for long-term care. Do you have any statistic on that?

Ms. McCarthy. Well, the size of the catastrophic illness issue for acute care is not huge. We are talking about less than 2 percent of the Medicare beneficiaries who experience catastrophic acute costs. Therefore, to the extent those costs were uncollectable—bad debts—certainly the hospital would not experience those, although, generally, you know——

Mr. Donnelly. How much is it?

Ms. McCarthy. Well, the Medicare program has a principle of being responsible for the bad debts of the Medicare beneficiary so

that it is not a tremendous transfer you are going to see in inpatient care. I think very important on the whole catastrophic issue is that it is a good first step, but it is a little difficult to look at that and then look at the administration proposals to eliminate $4.7 billion out of the basic Medicare program at the same time that we improve the benefit for the less than 2 percent of the beneficiaries.

Chairman STARK. Thank you.

Before the panel leaves, first of all, Mr. Newman, yours was the most refreshing testimony I have heard in a long time on this committee. I think that none of the medical delivery community—hospitals, physicians, or anybody else—can hold their heads up in the District of Columbia or Alameda County where infant mortality runs 20 in 1,000, which is higher than some of the lesser developed nations, for gosh sakes.

For anybody to talk about quality and the idea of taking care of uncompensated care or charity care with that kind of condition existing in their own community is an arrogant obscenity, in my opinion. You are quite right. We just ignore those sorts of things and look at individual subspecialties or individual groups of financial institutions rather than institutions that used to have a community thrust. It is difficult to do in this day of responding to budget cuts, but, hopefully, there will be another January 21. [Laughter.]

In that far-off, distant future, the pendulum may indeed swing again, and we may be able to deal with some of those things more aggressively. Where we will find the money to pay for it is another issue, but I thank you for kind of getting us back on a track that has some real importance.

I would ask Dr. McCarthy, first of all, if there is some reasonable maximum rate of occupancy that is generally prescribed in the hospital industry as enough. You obviously cannot run 100-percent occupancy. Is there a figure that is generally assumed to be a maximum occupancy rate?

Ms. MCCARTHY. When we were on a cost-based system, I think those kinds of figures had some foundation to them.

Chairman STARK. What were they then?

Ms. MCCARTHY. Well, it depended upon what kind of position you would like to be in. Certainly, anybody who was operating at 80 or 85 percent felt that that was good. They could handle heavy upswings or low, but they could also operate at less depending on the facility.

Today, though——

Chairman STARK. Let's assume for a minute that we wanted to move from 60–80 percent occupancy as a policy, that we would then be, in the aggregate, more efficient. Would a way to do that be just to let the guys who go marginally negative close so the occupancy of the others goes to 80 percent?

Ms. MCCARTHY. First of all——

Chairman STARK. Or—let me finish it up—should we, in your opinion, maintain these DRG payments at a level where there are no hospitals operating at a negative margin? Is that your position?

Ms. MCCARTHY. Let me start first and see if I can be responsive. I do not believe that talking about an 80 percent occupancy today matters in a payment system that is either preset price or capita-

tion or competition. It has no meaning. What has meaning is the hospital bottom line.

So, therefore, very important, and a good substitute for general occupancy, we ought to be looking at margins.

Chairman STARK. All right.

Ms. MCCARTHY. So it comes down to what are we comfortable with. If the question is the adequacy of the payment system, then we have to look at the patient revenue margin.

Chairman STARK. Are you willing to tolerate any of the members of the American Hospital Association operating with a negative margin? I mean, if you are not, then we have got a different payment problem.

Ms. MCCARTHY. I would hope that any hospital that is needed in this country—any one that is needed—would not be put in a position where its survival depended not upon its efficient operation but whether it was fairly paid. If the question to me is, can I envision hospitals closing?, certainly, I can, and I expect they have in the past; I expect they will continue to close across the United States.

Chairman STARK. You are not willing to speculate as to how many we ought to let operate at a negative margin, I mean, unless you want us to go back and just pick the ones that ought to close?

Ms. MCCARTHY. Well, I think that is about the only way that even you would have a comfort level, sir, if I may, because you would not want to say that if a facility is truly needed it ought to be operated at a negative margin. You would want to see that it is sufficiently funded to provide the care that is needed. Therefore, you would have to step back to make the first decision: I don't need that facility; therefore, I don't really care whether it operates at a negative margin until it goes out of business.

Chairman STARK. I guess you are saying we ought to go back to cost reimbursement.

Ms. MCCARTHY. No, I am not advocating that, either.

Mr. DAUNER. I would like to respond on the occupancy question. Desired occupancy is a function of size, location, and availability of alternative services, and a 30-bed hospital absolutely cannot operate at the same occupancy as a 500-bed hospital. The desired level in a single-hospital community of 30 beds may be 50 percent, and that would be an efficient occupancy, whereas, in a large community, a 500-bed hospital could operate at 87 percent and survive the fluctuations as well as the other parameters that affect inpatient utilization.

I think that, in any risk system, some hospitals are going to operate at negative margins, and the marketplace will take care of those institutions. The important thing is that the system not impose negative margins which transcend efficiency and the need for that facility to operate. That is really what we are trying to address.

Chairman STARK. Who do you think should make that decision? If you let the hospitals make it, they will obviously say that they are all needed, right? Have any of your members stepped up in California and said we ought to get out of business?

Ms. MCCARTHY. Well, with 81 closures in just 1985 alone, obviously, the decisions are being made.

Chairman STARK. Were any of those profitable hospitals?

Mr. DAUNER. No.

Chairman STARK. All right. So it is not being made just on the basis of voluntarily deciding they are sick of operating and getting out of the business.

Ms. MCCARTHY. If your revenues exceed your expenses and you are providing a service, why would you go out of business? I mean, you would assume that if that is your situation——

Chairman STARK. You might go out of business because you are operating at 50 percent and you are saying, look, we are really not doing anything but getting in the way. I cannot believe anybody would do that. I cannot see a hospital administrator quitting. But you might say, Look, we are hanging on at the margin; we have got a big endowment; let's give our endowment to a university where it will do more good and quit. Now, you find that saint-like person, and outside of the cloth, it is not apt to exist, in my experience.

Ms. MCCARTHY. And, hopefully, too, its community might consider that its decision was a saintly decision.

Mr. NEWMAN. It sounds to me as if this discussion has ended at exactly the same point where the first panel ended, which is an acknowledgment, or at least an implied acknowledgment, that there may be overcapacity in the system, but an unwillingness to say that the system that we have established which determines profitability should be the sole determinant of survival; that there may be institutions located geographically and with missions such that they will not be profitable given the sort of prudent-buyer notion that we are evolving here.

The problem is, how do you deal with the survival of those institutions that have to survive regardless of their profit margin and recognize that there may be some which are profitable but not profitable enough for their owners to wish them to continue to operate? So that dilemma seems to me to be at the base of all this.

But it is unreasonable to assume that the hospitals, which are always rational actors, are going to do themselves in voluntarily. It just will not happen.

Chairman STARK. I am going to steal an idea from my colleague. And California is at risk here, being one of the highest cost operators in the country, for reasons that often escape me. As much as I love California, I must say that when the costs of your procedures in California are as much over Atlanta as the cost of a first-class, round-trip airfare, California, is in danger of losing some business if we played this system right.

There are cases where California's procedures are so much more expensive that you could literally put somebody on United Airlines and fly them first class, round trip to Atlanta and let them have the same procedure there, and I would not want to argue with my colleagues from Georgia that the quality is any different.

And so when you get those kinds of distortions in the system, we begin to wonder what is wrong, and certainly historic costs then become something that we shy away from.

One member of our committee has suggested that maybe what if we find that the DRG system is not going to work as well as we want, why shouldn't we buy the lowest cost in any market? Why should we be dealing with averages? Why can't I do what Joe Cali-

fano does and say, Let me just find the person who wants to bid, who has the lowest cost in a market and make that the payment and let the rest of the operators figure out how to survive?

Mr. DAUNER. If you choose a selective provider contracting approach, which is what the Medi-Cal program in California actually is, and the price is reasonable and adequate, then it will work. In the State of California, Medi-Cal has contracted with 270 of 540 hospitals. However, they operate a monopsony by the way they set the rate, and that is why the losses are so great.

If Medicare established a policy of contracting with hospitals on a bid basis, as opposed to setting the price, as is done in California, then the marketplace might have a chance to function as it does in the private sector where there is negotiation between a private third-party payer, an employer, or a union and the provider. This relationship does not exist in the Medi-Cal program by the way it is operated at the State level.

Mr. NEWMAN. I don't know what the current figure is, but 25 million people who are uncovered by insurance seems to me to be a serious reason to worry about allowing this system to operate in a sort of inexorable market fashion.

Chairman STARK. I think you are right.

I want to thank all of you for your contribution today. Thanks very much.

Our third panel consists of Dr. Carroll Estes of the Institute of Health and Aging at the University of California in San Francisco; the General Accounting Office, represented by Dr. Eleanor Chelimsky, the Director of the Program Evaluation and Methodology Division; Dr. Bruce Vladeck, the president of the United Hospital Fund of New York; and Ms. Jo-Anne Andre, the vice president of the California Association for Health Services at home.

If you will proceed to summarize or expand on your prepared statements in the order that I called your names, I would appreciate it. Dr. Estes, would you like to lead off?

## STATEMENT OF CARROLL L. ESTES, PH.D., PROFESSOR AND DIRECTOR, INSTITUTE FOR HEALTH AND AGING, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Ms. ESTES. Mr. Stark and members of the committee, I will be speaking today from research that is in progress that involves a random probability sample of agencies that deliver services in the community to the elderly, including hospital discharge planners, hospices, home health agencies, nursing homes, adult day health care centers, community mental health centers, and senior centers drawn from five different States—California, Washington, Texas, Florida, and Pennsylvania—representing five Federal regions and nine standard metropolitan statistical areas.

The sample was selected, and the study was designed, to assess the effects of Medicare prospective payment (DRG's) on those providers of services in the community that represent the continuum of care available to prevent the elderly from being inappropriately institutionalized.

Based on preliminary findings, we have identified four major impacts of DRG's on the community care system for the elderly.

These are, first, that there are important changes in the clientele that these agencies are serving, and by and large, the change is toward serving a much sicker, frail population needing more critical care services. The agencies that have been most affected by these client changes are home health agencies, hospices, and nursing homes, although all components of the delivery system are reporting important impacts.

The second major impact of DRG's is on the services that are being provided. Providers are being pressed to offer more high-tech, skilled and critical care services, again with very high impacts, reported by home health agencies, hospices and nursing homes.

The third major effect of DRG's is on the ability of service agencies to refer their clients to other providers, particularly their increased difficulty in the ability to refer their clients to hospitals. This is especially a problem for hospices and community mental health centers but also a problem for home health agencies and nursing homes.

The fourth major DRG effect is a change in the ability of provider agencies to refer their clients to other community agencies because these clients have greater long-term care needs; there are fewer available community resources; there are longer waiting lists; there are no sources of payment to support much of the care that is needed; and, literally, their clients are too sick to be referred or accepted by the other agencies.

A key point is that DRG's and early hospital discharge have highlighted the problems that Medicare does not cover essential services needed even under the assumption that Medicare will cover the cost of acute care of the elderly for a spell of illness.

There has been, simultaneously as a result of DRG's a reduction in Medicare benefits—the reduction or loss of the 2 days of hospital care and 21 million days of care rendered at home and the community rather than in the hospital—an increase in out-of-pocket health costs paid directly by the elderly. Literally, public policy has created a catch 22. Prospective payment has encouraged hospitals to release the elderly sicker and quicker. Meanwhile, Medicare home health policies are tightening home health services availability; There is decreased funding through block grants for social services, mental health, and other community services; and the out-of-pocket burden of cost of the elderly is increasing. There also has been a decline in the number of old people on Medicaid by 9 percent between 1981 and 1984.

As a result a no-care zone has been created, which consists of many elders released from the hospital sick and frail, unable to pay for needed care privately, trapped in the no-care zone by the DRG policy changes and more narrowly interpreted Medicare rules on intermittent care, being homebound, and needing skilled care. Also in the no-care zone are elders who are chronically ill, marginally mobile, but cruelly seen as too well to be eligible under Medicare for supportive health-related care that would keep them at home.

In my view, the hospital revenues or margins above the traditional hospital profit margin historically allowed for Medicare, which have been achieved as a result of the reduction in the length of stay in the hospital for Medicare patients under DRGs, should be

utilized to increase funding for post-hospital, transitional care needs that have been generated by DRG's.

The basic principle I would underscore in my recommendations is that Medicare should have responsibility for the payment for the health care of the elderly for a total episode of illness—that is, until the patient is recovered and rehabilitated from that illness, regardless of where the patient is placed for that care; that is, in the hospital, the ambulatory setting, the home or nursing home.

For the great majority of Medicare beneficiaries, the hospital is no longer the site of most of their care for a spell of illness. Medicare policy should acknowledge this. The site of much medical care has shifted out of the hospital not only because of prospective payment, but also because of technical advances that have permitted care to be offered in other sites.

There are several additional basic principles I would recommend: Medicare should require care planning by providers participating in the Medicare program to assure quality and appropriate care as well as cost containment. Mechanisms also need to be set in place so that the patient is protected in terms of both quality and access.

The home health care benefit must be improved to foster rehabilitation and functional independence under the extended concept of Medicare's coverage of the episode of illness. We need to lift the restrictions on the homebound, intermittent, and skilled care.

Nursing home care, similarly, must be opened up to Medicare beneficiaries for their rehabilitation for an episode of care. Respite care should be added for limited periods to avoid the exhaustion of care-givers physically, emotionally, and financially and the long-term institutionalization of patients unnecessarily.

Obviously, costs are an important concern, and prospective payment for home health and nursing home benefits needs to be considered. It would then be possible to lift the intermittent and other Medicare requirements for home health care and allow home health agencies to provide the services that are needed to elderly patients within some fixed or prospectively paid rate.

Another key principle is that there should not be any increases in the out-of-pocket costs of the elderly. The elderly have paid an increase in their part A deductible of 155 percent between 1981 and 1987. The part B premium has risen 86 percent in the same time. Research shows that the costs that the elderly are paying out of pocket far outpace the cost-of-living increases that they are receiving under Social Security. These out-of-pocket costs, of course, now approximate 16 percent and are projected to rise by 1990 to almost 20 percent of the income of the elderly. These costs, of course, are disproportionately borne by low-income minority and female elderly.

Finally, Medicare policy should not foster inequities among providers. It should not disadvantage and provide economic hardship to home health or other agencies that serve Medicare beneficiaries. An interesting finding from our research in 1986 is that home health agencies that provide a high percent of their services to Medicare patients—those that rely on Medicare for more than 85 percent of their revenues—are much more likely to report decreases in staff and decreases in overall revenues than home health agencies that are not so dependent on Medicare.

Another example of an inequity between different types of providers is the fact that there are relatively large reimbursements for services provided in the hospital while smaller reimbursement under Medicare for the same services being provided in the home.

Should Congress decide to implement any, or all of these recommendations, the PRO or other entities would need to review the care plans and care planning processes; and probably research and demonstrations would be needed.

In closing, the key concept is that Congress, Medicare, HCFA, and the PRO's need to be concerned about the elderly Medicare patient from the beginning of an episode of illness to the end—not just in one setting—the hospital or the doctor's office—and not just in one part of the spell of illness—that is, the beginning—but for the entire episode of illness.

Rehabilitation of the elderly from a spell of illness to the level of independence with Medicare support is both humanitarian and cost-efficient.

Thank you.

[Statement of Ms. Estes follows:]

Statement By

Carroll L. Estes, Ph.D.*

Mr. Chairman, it is an honor to testify before the Subcommittee on Health of the Ways and Means Committee, U.S. House of Representatives, on issues related to post-hospital care and community services for the elderly.

I am Professor and Chairperson of the Department of Social and Behavioral Sciences and Director of the Institute for Health & Aging, University of California, San Francisco. The views that I express today are my own and do not necessarily represent those who have funded my research or my employer. My observations are based on a decade of research in a sample of large urban U.S. communities and in all 50 states. The 1986 data reported here are drawn from 865 interviews with a random sample of seven different types of health and social service providers in nine metropolitan areas (SMSAs) in the states of California, Florida, Pennsylvania, Texas and Washington. Today, I will comment specifically about our research on the impact of Medicare policy changes and DRGs on post-hospital and community based care.

The dramatic increase in the numbers of elderly in the U.S. in the next 40 years will bring equally dramatic increases in the demand for health care services. Between 1980 and 2000, projections are for a rise of 43 percent in the number of hospital days for the age group 65 or older; of 37% in physician visits; and 77% in nursing home residents.

In terms of the effects of cost containment policies and other changes in the health care delivery system on the elderly, we know that:

- With the introduction of prospective payment through DRGs, hospitals decreased the average Medicare length of stay by 14% between 1982 and 1984, although the average length of stay of Medicare patients was already dropping before prospective payment (PPS) was adopted.

- National averages show that the average length of stay in hospitals under DRGs was 25% less than for other hospitals in 1984.

- Hospital admissions under the PPS actually decreased 1.7% in FY 1984, reversing the predicted trend and following a 2.3% increase in admissions in FY 1983.

- The average hospital readmission rate has risen from 11.5% before DRGs to 16.3% after DRGs, according to government studies.

- Discharges to both home health services and nursing homes have increased 37% and 40%, respectively.

- Hospital occupancy rates are the lowest in several years. FY 1984 reports showed an average hospital occupancy of 67.7%, down from 73.7% in FY 1983.

Given that prospective payment for hospital care under DRGs has reduced the length of stay for the Medicare elderly by approximately two days, we can effectively say that there has been a loss of a Medicare benefit -- two days of rehabilitation and care -- that had previously been provided in the hospital prior to the implementation of DRGs. The effects of this loss of benefits is now beginning to be documented in the literature (GAO, 1987) and in our own research.

For the elderly and their families, there have been increased days of care in the home and community, coupled with significant direct out-of-pocket cost increases in the hospital Part A deductible paid by the elderly. Between 1981 and 1987 the rise in the Part A deductible exceeded 155%, at least partly attributable to the shorter length of hospital stays, as well as the greater intensity of care, the admission of sicker patients to the hospital, and price increases. The Part B deductible and

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premium have also risen dramatically since 1981, 25% and 86%, respectively. One result is that increases in health care costs paid out-of-pocket by elders far exceed increases in their income (e.g., Social Security cost of living increase (COLA), etc.). The American Association of Retired Persons estimates that per capita outlays paid out-of-pocket are rising approximately 12% per year between 1985 and 1987, while the Social Security COLA for 1987 was only 1.3%. The disparity between medical costs and the ability of the elderly to pay continues to grow.

And Medicare covers only 49% of the elderly's health care costs. Today, the elderly pay the same percentage of their income (15%) for medical care as before Medicare. Excluding nursing home and long term care, the average out-of-pocket health expense for the elderly in 1984 was $1,055, more than three times the average spent by other Americans ($310). Including nursing home and long term care, the average out-of-pocket expense was $1,705. These out-of-pocket costs increase with age, and minorities and women carry the largest burden of these costs. For instance, single women 85 and older paid 42% of their income for out-of-pocket health costs in 1986. As a result, as a percentage of their income, the health care costs of the elderly are rising every year. These costs are projected to increase to nearly 20% of the income of the average older American by 1990.

It is easy to understand why, in a recent Lou Harris national poll of heavy users of medical care, more than one-third (36%) of Medicare recipients who note that they are paying higher medical costs also said that the cost of their medical care was unacceptable.

At the same time, recent government data show that, in spite of PPS and other cost containment efforts, the costs of medical care climbed 7.7% last year, exceeding the Consumer Price Index by seven times. Doctors fees rose 7.8%; hospital room rates were up 7.7% and prescription drugs were up 9% in 1986. Meanwhile, hospitals reported unprecedented profit margins, and recent estimates suggest that the revenues for hospitals have exceeded their costs by 12% to 15%.

It is reasonable to assume that the reduction of two days of hospital care has created more work in the home and in the community in caring for the elderly who are discharged earlier. The pressures that the reduced length of hospital stay have placed on community agencies have been documented, first in 1984 and again in 1986, in studies conducted by the Institute for Health & Aging at the University of California, San Francisco. Interviews conducted in the Spring/Summer, 1986, with a random sample of home health agencies, nursing homes, hospices, hospital discharge planners, adult day health care centers, community mental health centers, and senior centers (from nine SMSAs in five states) indicate that the effects of DRGs fall into four major categories. Community health and social service agencies are reporting:

1. changes in clientele, to sicker, more frail, acutely ill patients;

2. changes in services provided, in the direction of more skilled, high-tech and critical care services;

3. changes in the ability of service providers to refer to hospitals, with increased difficulties in being able to admit or readmit patients to the hospital; and

4. changes in the ability of service providers to refer elderly patients to other community agencies, with increased difficulties in such referrals due to:

   - the greater long term care needs of clients,
   - fewer available resources in the community,
   - longer waiting lists for services,
   - the absence of sources to pay for the services needed, and

- patients' being too sick to refer them to other agencies.

Our research has identified several trends resulting from policy changes that represent an early warning signal regarding the health care of the elderly. The research indicates that:

- Functions traditionally performed in the hospital and by nonprofit sector service agencies are being transferred to the home, including care for the frail elderly discharged from the hospital early because of DRGs. An estimated twenty-one million days of home care have been created each year as a result of early hospital discharges. Given that 80% of the long term care of the elderly is already provided by family caregivers (primarily women), this added burden of post-hospital care is a heavy one indeed.

- Federal funds for social services have been cut more than 20% since 1981 and federal funding explicitly for comprehensive services has all but vanished. The transfer of responsibility for many health, social and community services from federal to state auspices was achieved in 1981 by the block grant program in the Omnibus Budget Reconciliation Act. This was designed to allow states increased autonomy and discretion in providing necessary services to their particular populations. However, as the General Accounting Office has shown, most (70%) of the health and social service block grants in the states had no increases in their actual expenditures (after inflation adjustments) between 1982 and 1983. Total expenditures declined in almost all cases in preventative health and health services (PHHS) and social services (SSBG). Thus, contrary to the hope, states did not pick up the slack with their own funding.

- Due to the availability of Medicare reimbursement for high-tech, medically oriented home health care and retrenchments in federal funding for social services, providers of primarily medical or medicallyrelated services are faring better than those providing social supportive services. Specialized in-home services are increasingly being targeted only to those who are eligible for public or private reimbursement or payment. Agencies serving the low income have suffered and/or switched to clientele who have first or third party payment.

- The resources of community agencies are being increasingly directed to services for frail, very old patients who are homebound at the expense of the marginal but mobile (or semi-mobile) elderly who also need support services to avoid institutionalization and to remain in the community.

- The implementation of federal prospective payment DRG policies and early hospital discharge simultaneously with budget cuts in the Social Service Block Grant and Medicare policies that have increased the restrictiveness of home health care have set the stage for the emergence of a <u>no care zone</u> for millions of older Americans. In this no care zone are many older individuals who are released from the hospital sick and frail, but who are unable to pay privately for their needed home care, and perhaps even more cruelly, many others who are "too well" to obtain the care that could keep them at home and independent because they do not have an open wound or similar condition to warrant "skilled care."

The problem that the DRGs and early hospital discharge have highlighted is that Medicare does not cover essential services, even under the assumption that Medicare covers the acute care of the elderly. Medicare does not cover the total episode of care for a spell of illness, although this was Medicare's original intent.

Research on the Impact of DRGs

Preliminary data from an Institute for Health & Aging study of the impact of Medicare policy changes and DRGs on post hospital and community-based care for the elderly suggest the continuance and intensity of several trends we identified in our earlier research conducted in 1984. The data reported here were collected by telephone survey in 1986 with a random sample of home health agencies (N=193), nursing homes (N=197), hospices (N=26), adult day health centers (N=40), senior centers (N=109), community mental health centers (N=97), and hospital discharge planners (N=190), drawn from five states and nine metropolitan areas. Our research findings indicate that:

- The most severe impacts of DRGs on the provider organizations studied have been, predictably, on home health agencies, nursing homes, and hospices.

- All provider types studied report changes in their clients. The biggest impact was reported by home health agencies, where 91% reported changes in their clientele because of DRGs. 88.5% of hospices, 84.3% of nursing homes, 71.1% of discharge planners, 52.5% of adult day health centers, and 33.0% of community mental health centers also reported DRG-related changes in their clientele.

- A large majority of the provider agencies reporting a change in their clients indicated that they are seeing sicker patients. This trend is most pronounced in home health agencies, where 94.0% of those reporting an effect of DRGs say their clients are sicker, more frail, and need more critical care. The same trend is reported by 85.7% of discharge planners; 73.9% of hospices; 62.7% of nursing homes; 57.1% of adult day health centers; and 50.0% of community mental health centers.

- All provider types report DRG effects on the types of services they provide. Of the agencies most likely to report changes in their services (72% of home health agencies, 55.6% of nursing homes and 76.9% of hospices), the trend is clearly in the direction of high tech services, more skilled nursing and critical care.

- Two other DRG effects reported by service providers are changes in their ability to refer clients to the hospital and to other agencies. Hospices cited the greatest difficulty in referring clients to hospitals as a consequence of DRGs (60% reporting), followed by community mental health centers, home health agencies, and nursing homes.

- Increased difficulties with referrals to other providers and agencies were a problem for more than one-third of the home health agencies, primarily due to the unavailability of community resources, the lack of reimbursement to pay for the services, and patients too sick to refer to other agencies. An alarmingly high proportion of hospices (79.2% reporting) and discharge planners (69.3%) report difficulties with referrals to other providers as a result of DRGs, citing similar reasons.

Our research findings are corroborated by a recent study by the General Accounting Office of access to post hospital care based on a nationally representative sample of 985 hospital discharge planners. Respondents in the GAO study cite problems in gaining access to post hospital care for Medicare elderly both for skilled nursing facility (SNF) and home health services, indicating that Medicare rules and regulations are the major barrier to this access.

Changes in the Home Health Industry

One effect of recent policy changes has been a dramatic transformation of the home health industry. While the industry

as a whole has undergone considerable expansion in the past decade, growing 64% between 1972 and 1982, the greatest rate of growth has occurred in the number of agencies that are for-profit (+1360%) and in institutionally-based agencies (SNF based: +357%; hospital based: +119%). However, Medicare certified agencies, which increased by 23% from 1983 to 1984, grew by only 9.5% in 1985 and 2.6% in 1986 according to HCFA. And just as importantly, there has been a recent decrease in the rate of growth of Medicare home health expenditures; Medicare payments rose by 36% from FY 1982 to FY 1983, 27% in FY 1984 and down to 21% in FY 1985.

Simultaneously, there has been a decline of 4.9% in the percent of total charges reimbursed by Medicare -- from 86% in the pre-DRG period (FY 1982), to 82% (FY 1986) according to HCFA Medicare home health data as of June 27, 1986. As significantly, there was a decline in the total number of Medicare home health services between 1984 and 1985 (-8.6%) and in the total number of visits (-11.1%) for the same period, the year in which DRG implementation was to be completed. Although the HCFA data are not yet complete, some are predicting that there will be no expenditure growth in Medicare home health services between FY 1985 and 1986.

A related (and unexpected) finding of our own research which is a major change between 1984 and 1986, is that home health agencies that rely heavily on Medicare reimbursement (rather than private pay and private insurance) can find themselves in serious difficulty in terms of their own financial viability and ability to serve their patients, particularly those who are neediest. According to our 1986 data, home health agencies that depend on Medicare for over 85% of their revenues are more likely to report both budget and staff decreases and the inability to provide personal care and social support services because of Medicare reimbursement limitations.

Medicare fiscal intermediaries have tightened up on the claims approval process, and some say they are being asked by HCFA to meet target denial rates. The arbitrary and restrictive judgments, particularly concerning the "intermittent care" rule by Medicare fiscal intermediaries have been cited as a growing problem in other Congressional committee hearings. Home health care is differentially more available to those who can afford to pay out-of-pocket fees or have private insurance than to those who do not have these sources. Paradoxically, given the uncertainty and restrictiveness of Medicare, even Medicare patients are likely to find it increasingly difficult to obtain services as more and more home health agencies seek to reduce their dependency on Medicare as a funding source.

Recommendations

In summary, DRGs have initiated a process of deinstitutionalization -- the deinstitutionalization of the elderly from the hospital. In an important sense, the same cruel mistake made when the mentally ill were deinstitutionalized in the 1960s is being replicated in the 1980s. Now the elderly are being deinstitutionalized from the hospital without regard for the community care that is essential to meet their needs for recovery and rehabilitation. Federal policies have created the proverbial Catch 22 -- pushing the elderly out of the hospital sicker and quicker because of hospital prospective payment policies under Medicare, while at the same time cutting back funding for social, mental health and other community services through block grant programs, tightening up Medicare home health benefits, and freezing Older Americans Act funding for community-based care. The burden on families has increased, and a seriously strained and under-funded community service system has been left to deal with the millions of extra days of care that earlier had been provided in the hospital. Meanwhile, the out-of-pocket costs for the elderly have soared, and under federal and state fiscal austerity policies, the number of elders on Medicaid has declined.

It is clear that the elderly have experienced the loss of a benefit in acute inpatient and rehabilitative care with the shortened length of stay, and without the addition of commensurate provisions for care related to the spell of illness outside the hospital. I believe that the evidence shows us clear and obvious ways to address the unintended but, nonetheless, very real difficulties created that jeopardize the recovery and rehabilitation of millions of elders, add to their financial burdens, and place serious strains on their caregivers.

In my view, the $3 billion in hospital revenues (above the 3% hospital profit margin historically allowed by Medicare) achieved as a result of the reduction in the hospital length of stay under Medicare should be utilized to cover the increased post-hospital, transitional health care needs that have been generated by DRGs. What follows are some ideas and recommendations about how this might be accomplished.

The first and basic principle underlying my recommendations is that Medicare should have responsibility for the payment for an older person's health care for a total episode of illness -- that is, until the patient is recovered and rehabilitated from that illness -- regardless of where the patient is placed for that care (ambulatory settings, in the home, or in the nursing home). For the great majority of Medicare beneficiaries, the hospital is not the site of most care for the spell of illness, and Medicare policy should acknowledge this. The transformation in the site of medical care has been accelerated by technological advances that permit more care to be provided at home and ambulatory care settings, and by the initiation of Medicare's Prospective Payment System for hospitals in 1983. The principle that Medicare should maintain responsibility for payment for services for a spell of illness regardless of the site of the services is consistent with Medicare's intent at the time of its passage. Medicare benefits should cover the full range of the elderly's health care through a spell of illness -- at least until the patient returns to functioning as independently as is realistically possible.

The second principle is that there is a need for care planning, particularly coordinated and managed care. This is essential to insure that issues of quality and appropriateness do not become lost in the drive for cost containment. It should be a logical principle that appropriate, quality, managed care <u>is</u> cost efficient care, both in the long and short run.

The third principle is that, with the need to emphasize cost containment, mechanisms must be set in place to protect the patient in terms of quality and access to needed services. This means not only that managed care has to become a prominent priority throughout the service system, but also that safeguards -- both individual and systemic -- must be developed to assure that the individual Medicare patient has the opportunity and assistance to appeal what he or she may interpret as denied care (from inappropriate early discharge to a rejected claim). The responsibility for care planning needs to be squarely placed on providers, and PROs should have responsibility both for seeing that such care planning occurs and that it is adequate. A plan of care should be required before a Medicare patient has access to nursing home, home health or other benefits under Medicare. Care planning, coordination and management should be required of providers to participate in the Medicare program, but it should not be necessary to pay for such assistance out of the three billion dollars in hospital cost savings described above. Likewise, PRO's and administrative agencies must have mandates that place the goals of equitable and adequate provision of necessary care above cost-cutting goals. In addition to carrier review, the PROs could be expanded (or other entities developed) to monitor physicians services for hospitalized Medicare beneficiaries and, more broadly, for ambulatory services as well.

The fourth principle is that the home health benefit must be improved to foster rehabilitation and functional independence. Specific policy changes are needed to lift the current

unreasonable restrictions regarding intermittent care and being homebound. Rehabilitative care until the patient has reached an independent, functional status, wherever possible, should be available for those Medicare elderly who experience an episode of illness and have the potential for rehabilitation. The needed acute care and rehabilitation services should be paid by Medicare Part A, whether the care is provided in the hospital, in the home or the community. Basic to the achievement of this goal is the extension of Medicare coverage under the concept of the episode of illness to include all appropriate sites of care and providers, particularly nonprofit agencies providing home health services. The extension of the Medicare home health benefit to cover the spell of illness would effectively mean the cessation of the harrassment of home health providers by the Health Care Financing Administration and Medicare's fiscal intermediaries; it would also mean the abandonment of targeted rates of retroactive claims denials for services already rendered to Medicare beneficiaries who needed them. Under legislative provisions assuring that Medicare covers needed health care for each spell of illness, home health agencies could (within a fixed DRG rate or other prospective payment mechanism) provide the range of needed health care services, without being restricted by the arbitrary, clearly punitive and counter-productive requirements of intermittent care, being homebound, or in need of only skilled care.

Fifth, nursing home care needs to be available and fully reimbursed to Medicare patients who require acute, subacute, or rehabilitative care in that setting. Provision of comprehensive and reasonable home health care, as well as respite care, would provide care for many elderly patients in more appropriate sites, allowing nursing homes the flexibility to provide care for those who need and would most benefit from care in that setting.

Sixth, respite for stressed and overburdened caregiving families needs to be available. The need for this type of benefit cannot be emphasized enough, given that research is now showing that more than 20% of caregivers will themselves suffer physical and/or economic problems as a result of their caregiving responsibilities. A respite care benefit would permit an elderly patient to be cared for in an adult day health care center, nursing home or other suitable setting for limited periods. Without this, more and more elderly will have to be permanently institutionalized because the burden on their caregivers is too great.

Seventh, cost containment considerations necessitate prospective payment policies for the home health and nursing home Medicare benefits that are expanded under the principle of covering the cost of a spell of illness.

Eighth, the cost of this health care should not be born by the elderly out-of-pocket. Mechanisms to cap these out-of-pocket costs should be implemented. As previously discussed, the out-of-pocket burden on the elderly is unacceptable and escalating by the day. Shifting more of the burden of cost to the elderly need not and should not even be considered a viable option.

Ninth, Medicare policy should not foster inequities among providers. Providers of home health to Medicare beneficiaries should not be penalized in comparison to providers who refuse to limit service to Medicare beneficiaries. Similar payments should be made for similar services among qualified providers, and the relative payments for different services should broadly reflect different costs. For example, if hospital services are rendered in the home, they should receive comparable payment as for those services when rendered in the hospital.

In summary, the goals of policy should be: (1) the provision of health care for the spell of illness until the patient is rehabilitated to independent status or has reached his/her limits of functional recovery; (2) assuring the appropriate level of care in a way that does not devastate the

elderly financially; and (3) assuring equity among health care providers.

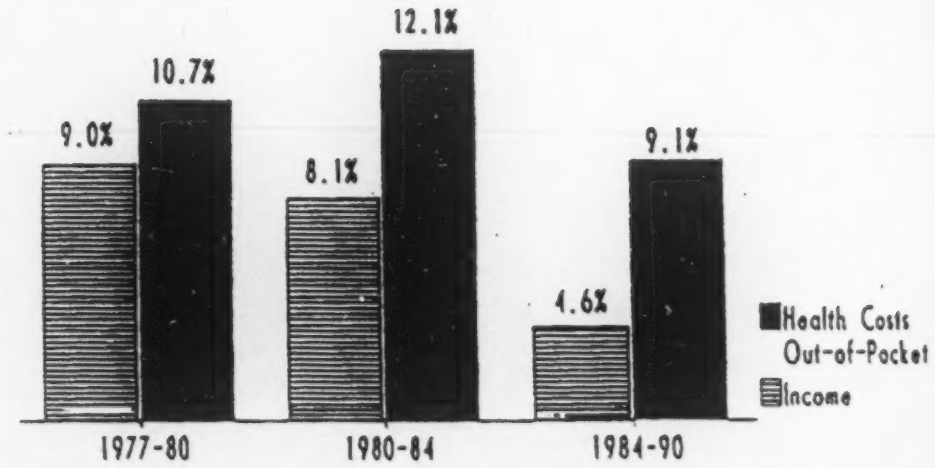
Should Congress choose to make such changes in Medicare, it would be necessary to institute mechanisms to assure that the fiscal intermediaries and carriers carefully oversee the quality and appropriateness of care. The responsibility of the PROs or other entities would need to be extended to include the review of care plans and of the full range of the health care services that are provided throughout the spell of illness. Studies and demonstrations should also be implemented to investigate alternate provider arrangements in the lead and consultive roles in care planning.

Assurances of access to and quality of health care must be paramount. The key is that Medicare, the Health Care Financing Administration, and the PRO's must be concerned about the elderly Medicare patient from the beginning to the end of the spell of illness -- not just in one setting (e.g., the hospital) or only during part of the spell of illness (e.g., at the beginning). Rehabilitation of the older patient to the level of independence with the support of Medicare is both humanitarian and cost efficient.

FIGURE 1

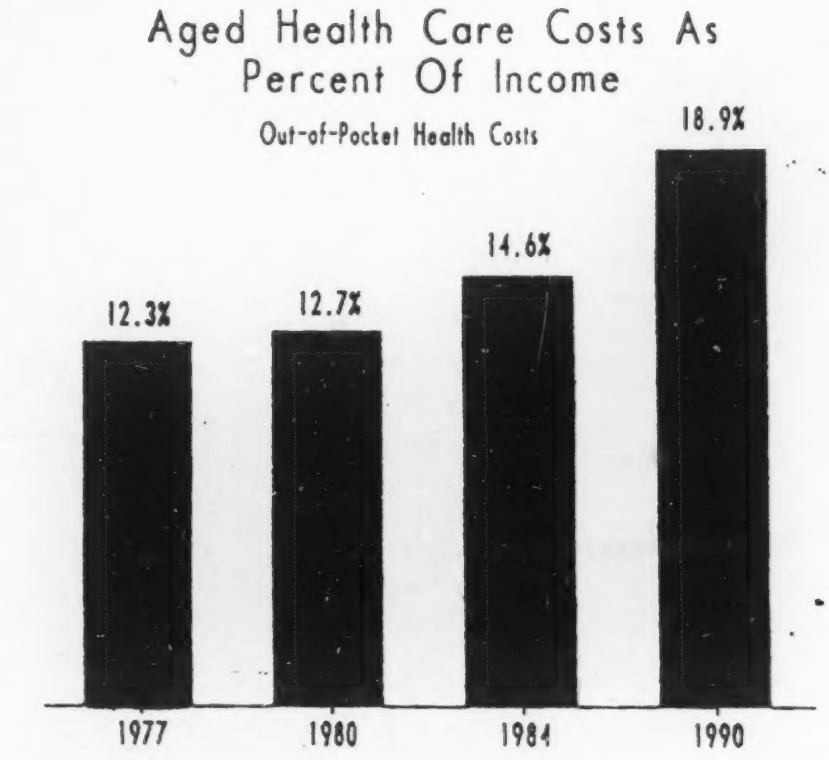
# Aged Income and Health Cost Increases

Annual Percent Increases




Source: House Select Committee on Aging, July 1985. Health Care Financing Administration, July 1985. Census Bureau, July 1985.

FIGURE 2




Source: House Select Committee on Aging, July 1985. Health Care Financing Administration, July 1985. Census Bureau, July 1985.

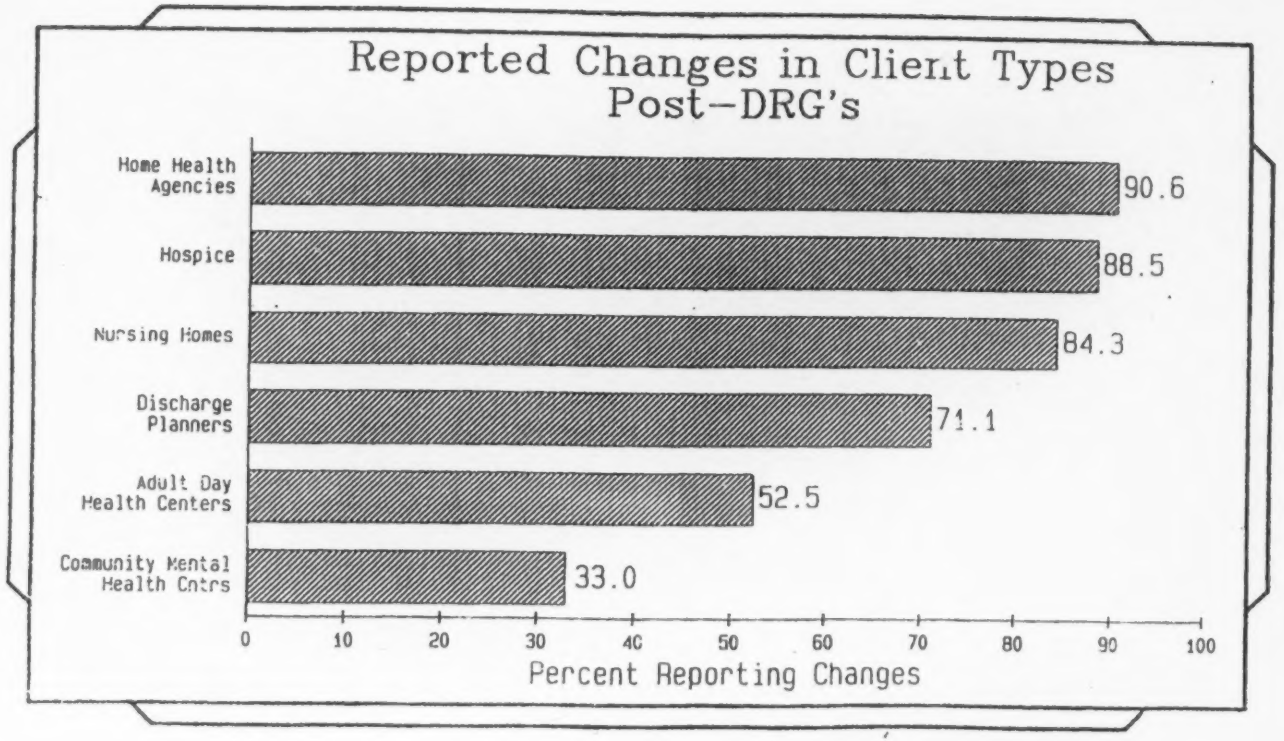
FIGURE 3

REPORTS OF EFFECTS OF DRGs ON AGENCIES SURVEYED

| Reports of Any Effects* by Type of Agency: | Yes | No | Total |
|---|---|---|---|
| Home Health | 181 | 11 | 192 |
| | 94.3% | 5.7% | 100.0% |
| Nursing Homes | 186 | 11 | 197 |
| | 94.4 | 5.6 | 100.0 |
| Adult Day Health | 27 | 13 | 40 |
| | 67.5 | 32.5 | 100.0 |
| CMHCs | 70 | 27 | 97 |
| | 72.2 | 27.8 | 100.0 |
| Hospice | 25 | 1 | 26 |
| | 96.2 | 3.8 | 100.0 |
| Senior Centers | 61 | 48 | 109 |
| | 56.0 | 44.0 | 100.0 |

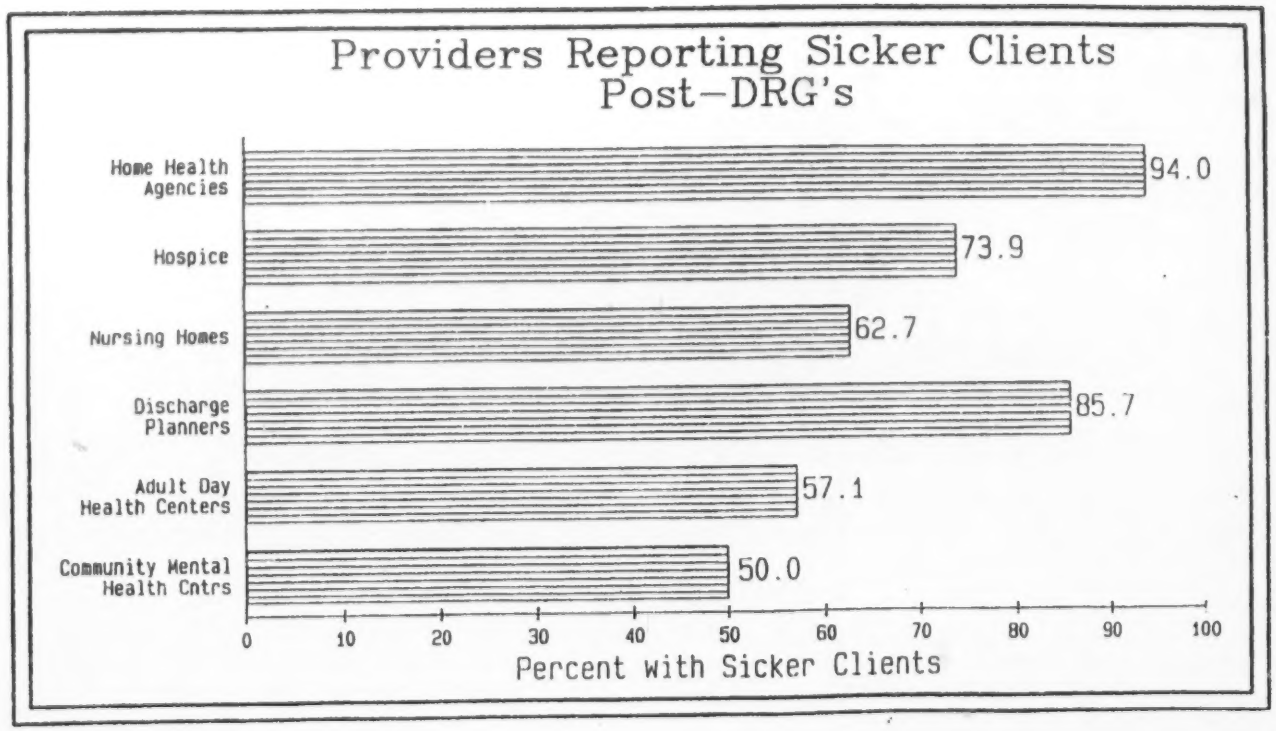
SOURCE: IHA, DIS Telephone Survey.

FIGURE 4




*Source: IHA Surveys*, 1986

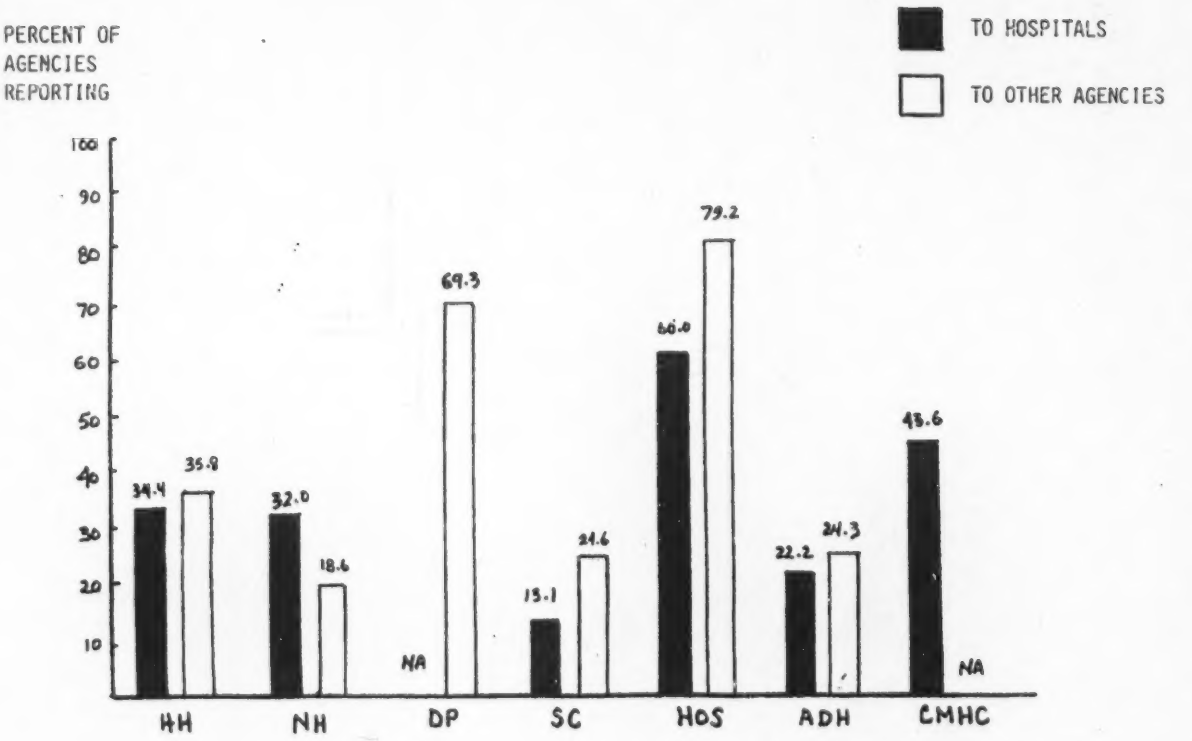
FIGURE 5




*Source: IHA Surveys*, 1986

FIGURE 6

CHANGES IN ABILITY TO REFER DUE TO DRG'S




SOURCE: IHA DIS SURVEYS -- 1986

Chairman STARK. Thank you.
Dr. Chelimsky?

**STATEMENT OF ELEANOR CHELIMSKY, DIRECTOR, PROGRAM EVALUATION AND METHODOLOGY DIVISION, U.S. GENERAL ACCOUNTING OFFICE**

Ms. CHELIMSKY. Good afternoon. It is a pleasure to be here.

I am going to be talking about the study that GAO has just done on the access of Medicare beneficiaries to posthospital care. It is a little bit different than what we have been talking about this morning, but not so different from Dr. Estes' work.

We began this study with two ideas in mind. First, the incentives associated with Medicare's prospective payment system, or PPS, which was implemented in October 1983, made it seem likely that the expected positive outcomes of PPS such as cost containment might very well be accompanied by negative outcomes such as increased difficulty of access to posthospital care.

We did an initial study of PPS in which we found, as did others with different studies, that there were indeed many local problems of access by Medicare beneficiaries, but no national study had yet been done, so what we wanted to do was find out whether the access problems we had identified existed across the country or just at these isolated local sites.

Second, we wanted to look at access in a more direct way than is usually possible, and this study provided us with an opportunity to do that; that is, instead of asking how much use there is of posthospital care or how many nursing homes or home health agencies there are for a given population and then inferring whether in fact access is sufficient or not, we posed a very basic empirical question: When Medicare beneficiaries are discharged from a hospital needing posthospital care either in a nursing home or through home health services, can they, do they, obtain it?

The study I am reporting on today, then, is the first nationwide look at this question, to our knowledge. We answered it by surveying discharge planners in a nationally representative sample of hospitals.

The reason we picked discharge planners is that they are the people who have the responsibility for placing Medicare patients in post-hospital care when the hospital has determined that it is medically necessary. So we have a proxy for need.

Our sample included 935 Medicare-certified hospitals of all types, and our response rate was 93 percent. I have five findings to report.

First, our survey shows that the quasi-totality of discharge planners nationally—that is, 97 percent—are experiencing problems in placing Medicare patients in nursing homes.

Second, 86 percent of planners reported problems in arranging home health care for Medicare patients. So it is very clear that, whether it be nursing homes or home health care, a large majority of discharge planners across the country are encountering problems for Medicare patients in accessing posthospital care.

The third finding was that more than half the discharge planners reported that problems of access in 1985 had increased com-

pared with 1982. This worsening of the situation was more often experienced in the eastern part of the country than in the West. However, there was little difference with regard to urban and rural areas. That is, discharge planners from both types of areas indicated increased problems of access.

Now, with regard to the reasons for access problems, our fourth finding is that, in the case of home health care, more than half the discharge planners identified the Medicare program's own rules and regulations as the chief barrier to access. One reason for this is that Medicare benefits simply do not cover certain types of services needed by Medicare patients, particularly nonskilled services such as homemaker, chore, respite, custodial care.

Finally, with regard to nursing homes, discharge planners pinpointed two major barriers to access. The first was, once again, Medicare's rules and regulations, but here the problem was not lack of benefit coverage, as in home health care, but, rather, changes in the way individual eligibility and coverage determinations are made.

The second barrier was a shortage of nursing home beds. This problem was most often reported in the Northeast and in the South.

In conclusion, then, whether we speak of nursing homes or home health services, our study confirms the existence nationwide of access problems faced by Medicare patients in obtaining posthospital care.

Discharge planners report that the problems they face are pervasive and, also, that they have increased in magnitude since 1982. What they are telling us is that Medicare PPS is driving up the demand for post-hospital care at the very same time that specific rules of the Medicare program are keeping that demand from being met.

That concludes my remarks. Any questions would be fine.

[Statement of Ms. Chelimsky follows:]

STATEMENT OF ELEANOR CHELIMSKY, DIRECTOR, PROGRAM EVALUATION AND METHODOLOGY DIVISION, U.S. GENERAL ACCOUNTING OFFICE

It is a pleasure to be here today to share with the committee some of the information we have developed over the past few years regarding the Medicare Prospective Payment System and posthospital care. Other panelists today have noted some of the ways in which hospitals have responded to the incentives of PPS--primarily through operational efficiencies and reduced lengths-of-stay. Granted, there is some disagreement about the precision and significance of estimated hospital profit margins.[1] However, PPS has other effects about which there can be little disagreement. I am referring to the effects of shorter hospital lengths-of-stay on Medicare beneficiaries and on their need for and access to posthospital care.

The results I present here come primarily from our recently released study of access to posthospital care for Medicare beneficiaries.[2] Because of the lack of nationally representative information on direct measures of access to posthospital care, we surveyed discharge planners working in a nationally representative sample of 985 hospitals. We received responses from 93 percent of these hospitals. We surveyed discharge planners because of their direct responsibility for assisting hospital patients in finding posthospital care. We asked the discharge planners about the problems they have encountered in attempting to arrange placements for Medicare patients in posthospital settings, primarily skilled nursing facilities (SNFs) and home health care. As such, our work represents the first national study of access to posthospital care for Medicare patients whose need for such care has been ascertained by hospital professionals. Of course, arranging placements for this particular subpopulation of discharged Medicare inpatients is only one aspect of the broader issue of access to nursing homes and home health care.

It is important to note that Medicare posthospital benefits were intentionally designed to cover short-term skilled nursing and rehabilitative care for patients recuperating from acute illnesses. The types and amounts of services covered are strictly limited, and there is substantial beneficiary cost-sharing in the case of the SNF benefit.[3]

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[1]Early last year because of the numerous problems we had identified with the databases used to calculate PPS payment rates, we recommended that the Secretary of the Department of Health and Human Services revise prospective payment rates and base the revision on data that reflect hospital circumstances under prospective payment. See Medicare: Past Overuse of Intensive Care Services Inflates Hospital Payments, GAO/HRD-86-25 (Washington, D.C.: March 7, 1986), p. 4.

[2]GAO, Posthospital Care: Discharge Planners Report Increasing Difficulty in Placing Medicare Patients, GAO/PEMD-87-5BR (Washington, D.C.: January 1987).

[3]Under current rules, Medicare SNF benefits are limited to individuals who need skilled nursing or rehabilitative services on a daily basis following a period of 3 or more days of hospitalization. Rehabilitative services are limited to persons who are expected to be "rehabilitated" and to return to independent living. For covered SNF stays, Medicare requires no beneficiary deductible, but after the 20th day, beneficiaries pay a large daily copayment (currently $65) for the next 80 days of care, and Medicare pays nothing at all after 100 days of SNF care (except for covered ancillary services).

There is currently no copayment for home health services covered by Medicare (except for durable medical equipment furnished by the home health agency), but coverage is limited to persons who are confined to their homes under the care of a physician and in

My remarks today focus on the size and direction of problems reported nationwide in placing Medicare patients in appropriate posthospital care, on changes over time in these problems, and on the underlying reasons discharge planners cite for these problems. In addition to learning whether discharge planners have difficulty placing patients nationally, and not just in individual sites, we were interested in understanding the impediments to arranging posthospital placements. Therefore, most of our questions were accompanied by a list of potentially important barriers to placements for the respondents to consider. The list was developed from our prior work and included

-- Medicare program rules and regulations[4];

-- Medicaid program rules and regulations;

-- the availability of services;

-- social or legal situations such as living conditions, family arrangements, guardianship, and conservatorship;

-- the need for complex or skilled services such as for feeding, IV's, respirators, and the like;

-- chronic care for such problems as Alzheimer's disease, pulmonary disease, incontinence; and

-- other problems.

I will allude to these barriers throughout my remarks in order to provide a clearer context for understanding access problems as perceived by discharge planners.

THE PROBLEMS REPORTED BY DISCHARGE PLANNERS

Across the nation, 97 percent of the discharge planners across the nation reported at least some problems in placing Medicare patients in skilled nursing facilities.[5] The problem they identified most frequently as a barrier to SNF placement was Medicare program rules and regulations. This was noted by 71 percent of the discharge planners. Next came the availability of beds and the need for complex skilled services, cited by 63 percent. Of the problems listed in the questionnaire, the only one selected by less than 50 percent of the discharge planners was the presence of chronic care needs.

To the discharge planners nationally, home health care placement is slightly less a problem than SNF placement. Eighty-six percent reported having had at least some problems arranging home health care for Medicare patients. Of those who reported specific barriers to home health placement for Medicare patients, 68 percent identified Medicare program rules and regulations as an important barrier. Chronic care problems were identified by 40 percent. But the availability of home health care was identified as a problem by only 29 percent of the discharge planners.

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need of part-time or intermittent skilled nursing services or physical or speech therapy. Home health aides, occupational therapy, medical supplies, and medical equipment may also be covered for patients who require skilled nursing services.

[4]I will clarify what is meant by Medicare program rules and regulations when I present some details of discharge planners' open-ended comments later.

[5]Information on sampling error and tests of significance for the statistics cited in this testimony can be found in GAO/PEMD-87-5BR.

ACCESS PROBLEMS HAVE REPORTEDLY WORSENED

More than half the discharge planners across the nation reported that access problems were greater in 1985 than in 1982. Discharge planners saw the introduction of Medicare or state-sponsored prospective payment systems for hospital services as contributing greatly to access difficulties, but they reported several other factors as also making it somewhat more difficult to place Medicare patients in posthospital care. These factors include increased numbers of Medicare patients, increased use of complex medical equipment and other "high-tech" services in posthospital care, the state regulation of nursing home beds through certificates of need, and changes in the number of certified SNF beds. An exception to this pattern was the growth in the number of home health agencies, which was seen as making the placement of patients somewhat less difficult.

REGIONAL ACCESS VARIES

Some regional differences in the discharge planners' views of access to posthospital care are apparent when we compare the results from the seven regions in our survey: Northeast, South, East North Central, West North Central, West South Central, Mountain, and Pacific. Problems with Medicare rules and regulations were identified most frequently as a barrier to SNF placement by discharge planners in the Pacific region. Discharge planners in the Northeast and South mentioned the supply of nursing home beds more frequently. With respect to home health care, a single pattern holds for each of these regions: a relatively large percentage of the discharge planners selected Medicare program rules and regulations as a problem.

The reported change in access between 1982 and 1985 varied considerably by region. In the Northeast, South, and East North Central regions, 59 percent or more of the discharge planners reported that the percentage of patients who had to remain in the hospital waiting for posthospital placement was greater in 1985 than in 1982. In two regions, West North Central and Pacific, the majority of the discharge planners reported no difference or a decrease in the percentage of patients waiting.

MEDICARE PROGRAM RULES AND REGULATIONS ARE SEEN AS THE MOST IMPORTANT BARRIER TO ARRANGING POSTHOSPITAL CARE

In addition to asking the discharge planners which of several factors contributed to difficulties in placing patients, we asked them to identify the most important barrier. With regard to SNF placements, roughly equivalent numbers of discharge planners viewed Medicare program rules and regulations and the availability of beds as the most important barrier. Thirty-three percent cited Medicare program rules and regulations. Almost as many, 30 percent, thought the availability of beds was the most important problem. However, with regard to home health placement, 52 percent chose Medicare rules and regulations as the most important barrier. No other factor was selected by more than 15 percent of the discharge planners.

In terms of regional variation, the percentage of discharge planners who identified Medicare program rules and regulations as the most important barrier to SNF placement was larger in the Mountain and West North Central regions than in the Northeast and South. The availability of nursing home beds was identified by a larger percentage in the Northeast and the South. Approximately equal percentages of discharge planners in the West South Central region identified this factor and the need for complex skilled care as the most important factors.

Discharge planners in each region reported Medicare program

rules and regulations as the most important barrier to home health care.

Finally, we encouraged the respondents to provide us with "any other comments" they had on posthospital care for Medicare patients. Fifty-four percent chose to do so. The responses helped to clarify some of the issues implied by the selection of Medicare rules and regulations as a placement barrier. The comments addressed two major issues:

-- a perception that the Medicare program has changed the way in which individual eligibility and coverage determinations are made and

-- a sense that posthospital benefits do not cover all the types of services the elderly need.

With respect to SNF services, the respondents focused on perceptions that there have been cuts in coverage, a tightening of eligibility determinations, changes in criteria for coverage and eligibility, and an increasingly restrictive definition of skilled care, making it more difficult to place Medicare patients in SNFs. Other discharge planners commented that some patients are very difficult to place in SNFs because their needs are either too great for SNFs to handle or too costly, given Medicare reimbursement. Such patients include those on respirators, those with multiple decubitus ulcers, and those requiring extensive observation.

With respect to home health services, the respondents noted the lack of coverage for nonskilled services in the absence of skilled care needs (or the cutting off of nonskilled services before patients are ready to function without them). The types of nonskilled services mentioned most often included homemaker, chore, extended observation, and "custodial" and "chronic" care services. In addition, the supply of related community-based services such as meals on wheels and home visitation was cited as a problem.

THESE PROBLEMS WERE PREDICTABLE

Prior to PPS, when hospitals were reimbursed for the cost of individual services and days of hospital care, their financial interests could lead them to err on the side of providing too much health care. At times this could have negative consequences to quality, given the danger of complications and infection that accompany all medical interventions, but the prime objection to this reimbursement method was its cost. Medicare was seen as paying for too much unnecessary and inappropriate care.

In shifting to a system of prospective payment based on diagnoses, Medicare removed the financial incentive to provide more health care services than needed. Instead, hospitals now stand to gain the most by curtailing both services and days of hospital care wherever possible. Hospitals can profit financially from cutting back on medically appropriate as well as inappropriate services. Thus, the extent to which patients are discharged while still in need of acute hospital care was seen as a potential problem when PPS was enacted and has, in fact, become a primary concern.

Another concern relates to the ability of hospitals to respond to PPS incentives by arranging for the provision of subacute care in appropriate posthospital settings. Patients who no longer require acute care should be discharged from the hospital. But some of these patients are still not sufficiently recovered to care for themselves at home, requiring appropriate and competent posthospital care.

Even prior to PPS, there were problems in obtaining access to skilled nursing facilities for some patients. As a result, some of these patients remained in hospitals longer than medically

necessary.[6] This is less likely to occur under PPS because such extensions of hospital stays have changed from being generally profitable to being relatively unprofitable. Pressure to discharge patients combined with problems in nursing home access could mean that some patients end up with less than optimal placements.

Similarly, with the regard to home health care, we found that problems of unmet need existed prior to the introduction of the Prospective Payment System. In 1982, an estimated 168,000 of the chronically-ill elderly lacked needed assistance with such basic activities of daily living as bathing, dressing, eating, etc.[7] These unmet needs reflect some of the same gaps in coverage for unskilled care that discharge planners cited in our current study as a barrier to appropriate home care placements.

The information that is available indicates that hospitals have responded as expected in terms of these incentives: average lengths of stay are down and the number of patients discharged to posthospital care, including nursing homes and home health care, has increased sharply.[8] Evidence of some problems of quality stemming from these incentives has also emerged. There have been numerous reports of cases in which people have been discharged from hospitals in unstable medical condition or without adequate provision for posthospital care, or to inappropriate types of posthospital care.

We reported to the Senate Special Committee on Aging in February 1984, that the hospital, nursing home, and home health care administrators, discharge planners and patients' advocates with whom we met in six communities across the country agreed substantially that patients were being discharged sooner and in poorer health than before PPS.[9] We were told that there was an increased demand for posthospital care and that patients in the post-PPS period required more intensive services after hospital discharge. The results of our recent survey of hospital discharge planners indicates clearly that the problem of obtaining appropriate subacute care for some patients is national in scope and not limited to individual communities.

## SOME CHANGES DESIGNED TO ADDRESS PROBLEMS IN ACCESS TO POSTHOSPITAL CARE HAVE BEEN MADE BUT QUESTIONS REMAIN

Some changes have been made in the Medicare program since the problems associated with the introduction of Prospective Payment have surfaced. The scope of work assigned to Peer Review Organizations has been expanded to include review of the appropriateness of discharge planning as one element of a broader set of quality-of-care screens, more emphasis on indicators of

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[6]GAO, Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly, GAO/IPE-84-1 (Washington, D.C.: October 21, 1983), pp. 110-15; GAO, Ohio's Medicaid Program: Problems Identified Can Have National Importance, GAO/HRD-78-98A (Washington D.C.: October 23, 1978), p. 7.

[7]GAO, Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs, GAO/HRD-87-9 (Washington, D.C.: December, 1987), pp. 4-5.

[8]HHS, Report to Congress: The Impact of the Medicare Prospective Payment System, 1984 Annual Report (Washington, D.C.: November 1985), p. 6-13 and 8-6 to 8-12.

[9]GAO, Information Requirements for Evaluating the Impacts of Medicare Prospective Payment on Post-Hospital Long-term Care Services: Preliminary Report, GAO/PEMD-85-8 (Washington, D.C.: February 21, 1985), pp. 4-8.

underutilization, and more specific requirements to examine patient readmissions that may have been caused by premature or inappropriate discharge.

The Omnibus Budget Reconciliation Act of 1986 requires each Peer Review Organization to devote a reasonable proportion of its activities to reviewing the quality of services in a variety of settings including posthospital care settings. The Act also requires HHS to develop a uniform needs assessment instrument that evaluates functional capacity to be used in establishing the need for posthospital care services, and requires hospitals to have a discharge planning program as a condition for their participation in the Medicare program.

Important questions remain, however, about HCFA's ability to identify and correct problems related to access, quality and costs of posthospital care.[10] We have recommended that the Secretary of HHS do studies to evaluate factors contributing to unmet need for home care assistance and options for meeting the future home care needs of the elderly.[11] At your request, GAO is currently examining the systems in place to measure and monitor quality of care over the entire range of Medicare-covered services. We will be presenting to you this spring our preliminary analyses regarding strategies for assessing the quality of care that Medicare beneficiaries receive and for using that information to make systematic improvements in quality of care.

CONCLUSIONS

The incentives associated with the Medicare Prospective Payment System made a variety of potential outcomes likely: positive outcomes in terms of reductions in hospital costs and unnecessary services; negative outcomes in terms of quality of and access to care in general, and access to appropriate posthospital care in particular. Our survey shows that, in fact, access to posthospital care is a national concern. Problems are encountered by the vast majority of discharge planners in placing Medicare patients in appropriate posthospital settings. It is clear also that the situation has deteriorated: discharge planners report that the problems associated with placing Medicare patients in posthospital care are greater now than before Prospective Payment. Overall, discharge planners are telling us, first, that Prospective Payment is associated with increased pressure to use posthospital care and, second, that certain aspects of the Medicare program itself impede access to and use of appropriate posthospital care.

This concludes my prepared statement. I will be happy to answer any questions you or other members of the committee have.

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[10]GAO, Post-Hospital Care: Efforts to Evaluate Medicare Prospective Payment Effects Are Insufficient, GAO/PEMD-86-10 (Washington, D.C.: June 2, 1986).

[11]GAO/HRD-87-9, p. 58.

Chairman STARK. Thank you very much, Dr. Chelimsky.
Dr. Vladeck?

**STATEMENT OF BRUCE C. VLADECK, PRESIDENT, UNITED HOSPITAL FUND OF NEW YORK**

Mr. VLADECK. Mr. Chairman and Mr. Donnelly, I very much appreciate the opportunity to be here today, particularly because I do not have a study to report to you. [Laughter.]

I also, as a member of ProPAC, feel obliged, but quite happily, to defer entirely to my colleagues on the first panel in terms of their analysis of some of these issues. I have been asked to address the issue of the purely hypothetical case that some alteration in the way we have set prospective payment prices for the next fiscal year and thereafter might, under existing budgeting practices, make available.

Chairman STARK. You basically are here to tell us how to spend the money, is that right?

Mr. VLADECK. That is what I understand, which is the most pleasant assignment I have had in quite some time.

Chairman STARK. All right. You are the guy we have been waiting for.

Mr. VLADECK. It has been a long time. [Laughter.]

Also, I feel compelled to say—and Howard Newman beat me to the punch—that if you have a billion dollars or $1.5 billion, to take a hypothetical number, to spend and you wanted to look at the health care of the entire population of the United States, I am not sure you would spend it on Medicare beneficiaries at all.

There are 37 million people in this country who have no health care coverage, a large proportion of them children.

This committee has acted on those issues in terms of Medicaid eligibility and maternal and child health in the last couple of years. I don't have to tell you about that, but I think that is a question that does need to be raised.

Nonetheless, you can make the case—and I think Dr. Estes made it very well—that, to some extent, any potential savings to be garnered from changes in PPS prices do emerge from a reduction in the real volume of services being received by Medicare beneficiaries, and there is a very reasonable public policy logic, I think, as well as perhaps a political logic, keeping that money within trust fund-based programs.

In that regard, in dollar terms, the most dramatic impact of the changes in the health care system on the benefits and expenses of Medicare-eligible people since PPS started is on what has happened to the part A deductible. You led the charge last year in beginning to mitigate some of that effect. We are not yet back, even under current law, to Medicare beneficiaries paying a proportion of the total expenses of hospitalization equivalent to the proportion they were paying before PPS.

You are going to be looking at the whole issue of catastrophic coverage and the relationship between beneficiary liability and total expenditures this year, and particularly if there is a potential of new dollars in some form, I would think that is very appropriate

to look down the road in terms of mitigating future increases in the deductible.

Obviously, as well, as you talk about catastrophic care, you are going to realize that the major issues in terms of risk for catastrophic expense and catastrophically inadequate service among Medicare beneficiaries are in the long-term care sector, where Medicare has in fact been cutting back since the advent of PPS and not even maintaining the status quo in terms of the availability of services.

Other members of this panel have already commented on that, and I cannot add terribly much to what they have said except to make the observation that our problems with Medicare payment for long-term care services and some of the other problems with long-term care are really chronic problems; they are not acute post-PPS problems. We have been avoiding these issues for quite some time. That does not mean they are any less significant or any less consequential, but none of this is great news in terms of people who have been looking at these issues.

Given that, let me add four specific suggestions that I would recommend for your consideration. First, in terms of committee jurisdiction, most of the issues having to do with nursing homes are separated out from Medicare issues because Medicare pays for so little nursing home care. But, in fact, most nursing home residents who are paying privately or are being paid for by Medicaid are Medicare beneficiaries, and if we talk about a system of services for them, nursing homes are part of the system whether Medicare is paying for them or not.

At the risk of being somewhat parochial, I had the pleasure of serving on the committee of the Institute of Medicine at the National Academy of Sciences that issued a report almost a year ago on ways to upgrade the quality of care in nursing homes throughout the United States. It was a major study. It contained quite a comprehensive list of recommendations.

Some of the recommendations would have relatively modest costs to the States and the Federal Government. Most of them can be implemented, the committee believed, at essentially no cost altogether.

There has been a great deal of discussion about implementation of those recommendations, but there has been no action as of yet through the formal administrative rulemaking process, ostensibly because of concerns about cost implications. The costs here are relatively minor compared to any of the categories of what we are spending our money on. If you really want to make an impact next year on the quality of life of a lot of Medicare beneficiaries, I think in some way that might be the most significant thing you could do for a relatively small amount of money.

Second, we used to devote a lot of time, effort, and attention to experimenting, under the auspices of the Medicare program as well as Medicaid, with new ways of delivering long-term care services, new ways of financing long-term care services, and new ways of using providers. The PPS system itself comes out of 222 waivers and HCFA R&D money, as does much of what we know about how to do a better job of providing home care.

In the last 5 years, again ostensibly because of budgetary impacts, the pipeline on all research and demonstration has essentially been cut off except where you have had to legislate continuation of the On Lok waiver, continuation of the SHMO's, and so forth.

R&D is a longer term strategy. It is a relatively modest investment with a good track record of payoff. We don't know enough now for me to answer the question: if you had an unlimited amount of money, how would you design long-term care services and how would you pay for them? And there is an awful lot of work that we ought to be doing at relatively modest expense to figure out how to do these things better.

Third, I very much support the idea of going back to pre-1982 interpretations of eligibility and of coverage for the home health benefit and for the skilled nursing facility benefit, without any expansion relative to the existing statute in those benefits in order to address some of the problems the other panelists have made note of.

And finally, once upon a time in the Medicare program, we recognized the notion that there might be a short-stay, post-acute, hospital-based skilled nursing service different from what we tend to think of as the free-standing nursing home, which is generally not paid for by Medicare.

In the current Medicare program, the only case in which that service really exists is in rural swing-beds, where the preliminary evidence seems to suggest that we are identifying a short-stay post-acute population, average length of stay under 30 days, who benefit from that sort of institutional service under the same roof, and the initial evidence seems to be that that is having a positive impact on patients and their families as well as on the institutions providing these services.

As you noted earlier, Mr. Chairman, we have a lot of empty hospital beds. We have a lot of Medicare beneficiaries who need post-acute services. We have had trouble over time distinguishing that particular short stay, post-acute stay, from the chronic nursing home problem and, as a result, have narrowed the Medicare SNF benefit over time.

There is beginning to be a body of literature suggesting that maybe we ought to look very seriously again, perhaps incrementally in a demonstration way, at sort of reinventing the distinct part-hospital-based, short-stay, post-acute, skilled nursing benefit. I think that, over a relatively short period of time, might have a very positive impact on Medicare beneficiaries.

Thank you very much.

[Statement of Mr. Vladeck follows:]

Statement

by

Bruce C. Vladeck
President
United Hospital Fund of New York

Mr. Chairman, members of the committee, my name is Bruce C. Vladeck. I am President of the United Hospital Fund of New York, a philanthropic, research, and educational organization. I very much appreciate the opportunity to appear before you today to give you my views about possible changes in the Medicare program. In doing so, I must emphasize, I am expressing views that are entirely my own.

As you know, Mr. Chairman, I am a member of the Prospective Payment Assessment Commission (ProPAC). You have already had the opportunity this morning to hear from ProPAC's distinguished chairman, Dean Stuart Altman. As Dean Altman has told you, while we have undertaken some discussion of the issue of Medicare margins and "rebasing" in ProPAC, we have not yet adopted any particular recommendation. As a conscientious commission member, I therefore feel it would be inappropriate for me to add any comments on the suitability or magnitude of any possible "rebasing," other than to express my sympathy and agreement with Dean Altman's comments.

Nonetheless, I have been asked to offer some suggestions and recommendations relative to possible appropriate uses of any funds that might be made available, under current budgetary practices, from "rebasing" or other savings in the Medicare program. I am delighted to have the opportunity to do so, not least because it has been, comparatively, so long since we have been able to talk realistically about needed improvements and enhancements in Medicare, and since there is so much unfinished business in health insurance for the elderly.

Let me begin by saying that I think it is entirely appropriate to apply any savings generated in one part of the Medicare program to improved benefits or services for Medicare beneficiaries, even though, from a somewhat more global perspective, one could readily argue that Medicare beneficiaries as a whole are not the group in our population most in need of increased health care expenditures by the federal government. With 37 million people, most of them low-income and a majority of whom work, lacking any form of health insurance at any given time, it seems to me that a society more concerned with issues of simple justice would give top priority to their needs. Within the jurisdiction of this committee, for example, one could probably contribute more to the health status of the American population by investing any given sum of dollars in expanded Medicaid eligibility for low-income two parent families, or low-income families in the "notch" immediately above the federal poverty level, or in targeted services for pregnant women and low-income children. I am aware, however, that you, Mr. Chairman, other members of this committee, and other members of this Congress have made considerable efforts over the last several years to address some of these problems, not least those reflected in the Medicaid provisions of last year's Budget Reconciliation Act, and I need not belabor the point here.

Moreover, if one speaks specifically to potential savings available from some form of "rebasing," as is the topic immediately at hand, I believe a strong case can indeed be made for applying these savings to Medicare beneficiaries. While to some extent, the rationale for "rebasing" lies in technical problems and misprojections in the establishment of initial prospective payment rates, the logic of "rebasing" derives primarily from changes in the health care system that have occurred since the advent of prospective payment in October, 1983, many of which have had significant consequences for the elderly. We have, indeed, reduced the rate of growth in projected Medicare inpatient expenses, to a considerable extent by providing fewer services to Medicare beneficiaries. I am among those who

remain skeptical as to whether that reduction in services has produced any widespread adverse qualitative consequences. Nonetheless, I think a simple sense of fairness suggests that, if the federal government and the Hospital Insurance Trust Fund are in a position to identify significant savings from reduced services or increased costs for Medicare beneficiaries, those savings should be shared with the beneficiaries.

The most obvious place to begin to do so is with the Part A deductible. I know that you are familiar with this issue, since last year the Congress took a very significant step in controlling the rate of growth in that deductible. Nonetheless, largely because of reductions in lengths of stay for Medicare confinements resulting, in turn, to a considerable extent from incentives in the prospective payment system, Medicare beneficiaries, even after last year's legislation, are paying a larger share of the cost of inpatient hospitalization than they were prior to the enactment of prospective payment.

My ProPAC colleague, Dr. Harold Cohen, has informally provided the rough estimate that restoring the Part A deductible to a proportion of total hospital payment equivalent to that which prevailed before prospective payment would involve a reduction of the deductible to approximately $488 per spell of illness, as opposed to the current year's level of $520. My very rough calculation suggests that reducing the deductible to $488 would save Medicare beneficiaries approximately $2 billion per year, with an equivalent increase in Trust Fund expenditures. Of course, not all of those savings would redound directly to beneficiaries. Roughly 7%, I would guess, would represent savings in state share to state Medicaid programs which pay the deductible for duly-eligible beneficiaries. About 70% of the balance would affect holders of supplemental Medigap policies, and thus presumably be translated into either premium reductions for those policies, or benefit expansions.

In that regard, I would urge you to consider any further reduction in the deductible in the context of legislation you are currently considering to protect Medicare beneficiaries against so-called "catastrophic" expenses for Medicare-covered services. Such legislation, which I very much do hope you will enact this year, is also likely to engender significant changes in the nature of Medigap policies, which may provide additional benefits to the majority of beneficiaries who can afford such supplemental insurance. Thus, if "catastrophic" legislation is enacted, it might not be appropriate to reduce the deductible as far as $488. Merely freezing it, at relatively modest budgetary expense, for several years would be a significant accomplishment.

Aside from the issue of the deductible, the discussion of "catastrophic" insurance, I need hardly tell you, has repeatedly highlighted the fact that the most pressing concerns of Medicare beneficiaries, in terms of inadequacies in the current program, have to do with long-term care and post-acute services. It is important to note that problems in the financing of these services are chronic, and not solely the acute results of prospective payment. On the other hand, I would be negligent if I did not point out to you that, at the same time as prospective payment is increasing and accelerating the demand for improvement, the Administration has repeatedly and systematically sought to reduce existing statutory benefits for home health services and skilled nursing facility care by re-interpretation of eligibility guidelines, by more stringent reimbursement and payment practices, and by cracking the whip on the fiscal intermediary system.

My colleague and fellow panelist, Dr. Carroll Estes, will comment in more detail about needed improvements in the home health and skilled nursing facility benefits, issues about which she knows much more than I, or just about anyone else. But I would like to make a few observations in this regard.

First, we tend to forget that most nursing home residents, even when their care is paid for entirely by Medicaid or private resources, are Medicare beneficiaries, and thus the quality of nursing home care for all residents throughout the United States is an integral part of the delivery of health care to Medicare beneficiaries. It is now almost a year since a committee of the Institute of Medicine of the National Academy of Sciences, on which I had the honor of serving, issued a series of comprehensive recommendations for improving the quality of services to nursing home residents. Most of the recommendations made in that report can be implemented at no direct cost to the federal budget; the cost of the remaining recommendations was, quite correctly I believe, estimated by the committee to be relatively small in comparison to total nursing home expenditures. I needn't tell you that, to this point, none of the Institute of Medicine's recommendations have been implemented. In the short run, I can think of little that would have as beneficial an impact on the health services available to Medicare beneficiaries as the potential improvements in the quality of nursing home services embodied in those recommendations, and I would urge you to take whatever steps you can to expedite that process.

Similarly, in the years immediately proceeding the implementation of prospective payment, there was an extraordinary amount of research, experimentation, and demonstration of new long-term care service and financing programs going on throughout the country, much of it supported either by federal grants or contracts, or by Medicare and Medicaid waivers. In the last five years, that process of experimentation has largely ground to a halt, except in those instances, such as the On Lok program in San Francisco, or the Social Health Maintenance Organizations, in which Congress has had to specifically legislate authorization for continued experimentation. It is widely believed that the Administration's resistance to further experimentation has arisen from concerns about increased federal expenditures, although such increases, if they existed at all, would be relatively modest in comparison to total Medicare and Medicaid outlays. We are still an awfully long way from knowing what optimal long-term care services should be in most communities, and there are still many important unresolved issues concerning the relationship of such services to federal and state financing programs. So, if we are now in a position to talk about relatively modest expenditure increases on behalf of Medicare beneficiaries, I would urge you to give reinvigoration of long-term care research and demonstrations the highest priority. Our experience with Medicare 222 waiver programs and similar efforts over the last decade or so, not only in long-term care, has been extremely positive. Indeed, prospective payment itself was technically possible at all only because of experience garnered under Section 222 and 1115 waivers, which was in turn based on federal research investments. We are cutting off our noses to spite our faces if we do not renew our commitment to supporting such research and demonstration.

Finally, while I have deferred to Dr. Estes in terms of detailed discussion of the home health and skilled nursing facility benefits, I would like to make two particular observations. First, it is clear that, for whatever reasons, current fiscal intermediary interpretations of eligibility requirements for post-acute home care are rendering many Medicare beneficiaries, who are being discharged from acute hospitals earlier than they might have been in the past, ineligible for Medicare-covered services. I would emphasize again that remedying that situation involves not expansion of benefits, but rather their restoration to levels that existed just a few years ago.

Second, in terms of both benefit redefinition and research and development, we need to pay a lot of attention to the provision of skilled nursing care in hospital-based facilities. I think our experience with swing-beds in rural hospitals has been quite favorable, and has made available

to Medicare beneficiaries services they otherwise would not have been able to receive. With the continuing growth in need for post-acute rehabilitative and restorative services for Medicare beneficiaries, and the growing surplus of already-built inpatient hospital capacity in most communities in the United States, it may be time to go back to the original intent of the skilled nursing facility benefit as expressed in the initial Medicare legislation. We should systematically encourage the provision of relatively short-stay, post-acute, skilled nursing services in hospital-based facilities to a substantially broader degree than is now possible under existing conditions of participation and reimbursement practices.

I can't resist pointing out that the United Hospital Fund has an excellent book on that subject in press, which I will be happy to make available to you as soon as it is printed. But my concern is, I trust, not entirely parochial. I think this is a vitally important issue for new (or old) policy development (or redevelopment). If I had to intervene at one point in the service delivery system to improve the continuity and quality of care for post-acute Medicare beneficiaries, while mitigating the impact of shorter hospitalizations, it would be in the area of hospital-based SNF services.

I very much appreciate the opportunity to present these ideas to you. I would of course be delighted to respond to any questions or comments you might have.

Thank you very much.

Chairman STARK. Thank you.
Ms. Andre?

**STATEMENT OF JO-ANNE ANDRE, VICE PRESIDENT, CALIFORNIA ASSOCIATION FOR HEALTH SERVICES AT HOME, AND EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION OF ORANGE COUNTY**

Ms. ANDRE. Thank you.

Mr. Stark and Mr. Donnelly, thank you very much for asking me to come and talk about the effect of the DRG's, particularly on the home health care system as we are seeing it played out.

My statement will look at how the DRG's are affecting the patient mix being seen by home health agencies as well as how the Health Care Financing Administration's response to those changes is making it more and more difficult for home health agencies to adequately care for Medicare patients who are being discharged quicker and sicker from hospitals. I will conclude by asking for some assistance in resolving some of these problems.

Basically, to summarize, the DRG's are increasing the number and the acuity of Medicare patients admitted to home health agencies. The hospital length of stay nationally has been decreased by 2 days; in California, by 1 day.

What we are seeing in studies that are coming out now is that a report from the U.S. Senate Special Committee on Aging shows that there is a 37-percent increase in patients being discharged to home health agencies over and above those being discharged prior to DRG's and that the number of visits also is increasing substantially.

The reason for this is obvious. As you have heard other panelists speak to, patients are coming home much sooner and they are coming home much sicker. The kinds of high-tech services that we are providing at home are services that would have only been provided in a hospital in the past and often in intensive care units.

Just to give some brief examples, we are seeing continuous intravenous morphine drips at home; we are seeing patients at home on 24-hour ventilator-type care; we are seeing patients with large, open, draining wounds; and we are seeing the increased acuity causing a need for more visits, a need for more skill on the part of the nursing staff and the rehab staff providing the visits, and also more time needed for each visit.

In response to that, however, we are seeing just the opposite of what you might expect, and we are seeing HCFA trying to clamp down upon the Medicare home care benefit. We are seeing HCFA encourage fiscal intermediaries to make restrictive coverage decisions.

As was spoken to earlier, the rules as to what is homebound, what is intermittent care, what is medically necessary care, have not changed in the home health agency manual per se, but they seem to have changed drastically in terms of the interpretation that is being made of those coverage decisions right now.

The denials are occurring not only in specific instances like that, but two or three visits are being denied on a case, not giving you any specifics as to why it was too much but simply saying, We

think this person should have been able to learn this care sooner; we think this wound could have healed with less visits, often without even requesting patient records for review to see if that is an appropriate decision to be making.

Because the agencies can no longer discern what is covered and what is not covered care, they are becoming more conservative in the amount of care that is being delivered, and the average number of visits per beneficiary is falling. In California, the average number is estimated to have fallen from about 15 in 1985 to 11 visits per beneficiary in 1986.

In spite of this, we are seeing massively increased denials. Nationally, in 1985, 3.5 percent of all home health claims that were submitted had at least one visit denied. To give you a sense of how this is escalating, by the third quarter of 1986, 7.5 percent of all claims had some visits denied, and in region IX, California, in the third quarter, this was 10 percent.

In addition to not being able to get a clear definition as to what is covered and what is not covered, and increasing denials which we feel are often inconsistent or arbitrary, we are also seeing a shrinking in the amount of money being paid to home health agencies. The cost limits are scheduled to be reduced from 115 percent of the mean to 112 percent of the mean on July 1, 1987.

This does not take into account the fact that the patient's acuity is much more severe. It also does not take into account the administrative costs imposed upon home health agencies by the paperwork nightmare of the implementation of the 485, 485, 488 forms or an inflationary factor.

Also, as the committee is well aware, there has been a slowdown in payment to home health agencies. Not only do you not know what you will and will not be paid for; not only are you going to be paid at a lower rate; but you also do not have any idea when you will be paid.

I know that congressional action has asked for payment of clean claims within 30 days. However, I need to bring to your attention that this is not necessarily happening. At a major fiscal intermediary in California, 22,000 claims were backlogged at the end of 1986, and the number of claims processed in the fourth quarter after Congress had asked for fast payment on claims was half of what had been processed in previous quarters. In speaking to fiscal intermediaries, they indicate that this is as a result of HCFA budgetary constraints upon them.

The recent GAO study that was cited by Carol Estes also indicates that discharge planners are having more difficulty in finding appropriate home care services for Medicare beneficiaries. Once they are admitted, they get fewer visits.

I would like to give you just one or two examples so you can see that we are not talking about unnecessary care being denied but necessary care that is being denied. These examples are from Stanford University Medical Center, where a 79-year-old patient was admitted to the home health agency after being in a hospital for 2 months. He had a fracture of his second vertebra, had had multiple surgeries, and came home in halo traction with a large, open, draining wound.

The physical therapist was able to teach him to walk to his bathroom and to ambulate sufficiently within his home.

The fiscal intermediary denied all the care because they said the patient was no longer homebound if he could ambulate within the house.

Another example is a young cardiac patient awaiting a second heart-lung transplant. The patient was so ill that she was determined not to be well enough to go through the second transplant and was sent home with home health services to monitor her condition and report to her physician and to provide chest physiotherapy.

Over half of the visits were denied as medically unnecessary, and the patient subsequently was so unstable that she died prior to being able to have a transplant.

The things that I would ask from you legislatively are that coverage rules be clarified and, as was pointed out by this panel previously, that, since there has been no change in the manual as to what is homebound, what is intermittent, what is covered care, that we go back to the interpretations that were intended under that manual.

If that is not the intent, then perhaps new regulations should be formulated giving us a chance to have a chance for public input. But to simply reinterpret regulations without reissuing new regulations is something we would ask you not to permit.

Also, I would ask you to look at the cost limits that are scheduled to go into effect and to see if they need to be adjusted in any way to reflect the sicker patients coming home as a result of the DRG's and also to look at the added administrative costs that HCFA has imposed upon the home health agencies.

The third thing we would ask is that you look at asking fiscal intermediaries to respond to your request that claims be paid promptly and that adequate budgetary monies be given to fiscal intermediaries to permit that to happen.

In summary, we would like to see that the Medicare beneficiary receives the care at home that is necessary, since they are coming home so much sicker under the DRG's.

Thank you.

[Statement of Ms. Andre follows:]

**Statement of Jo-Anne Andre'**
**Vice President**
**California Association for Health Services at Home**
**Executive Director**
**Visiting Nurse Association of Orange County**

**Presented to the Subcommittee on Health of the House Committee on Ways and Means February 26, 1987.**

## I. Introduction

The focus of my testimony is on the impacts of the hospital Diagnosis Related Groups (DRG's) on another sector of the health care delivery system: home health care. In evaluating the intended and unintended effects of DRG's, it is important that these effects in other sectors be considered. My statement will look at how DRG's are affecting the patient mix being seen by home health agencies, how the Health Care Financing Administration has been responding to these changes, and the net effect on access to, and the quality of, care received by elderly and disabled Medicare patients. I will conclude with several recommendations for the Subcommittee to consider.

## II. DRG's Are Increasing the Number and Acuity of Medicare Patients Admitted to Home Health Agencies

It has been frequently documented that DRG's are causing patients to be discharged from hospitals sicker and quicker. In California, for example, the average length of stay for Medicare patients has declined by nearly one day since the advent of DRG's.[1] What has not been as well documented is that home health care is feeling some of the strongest effects of DRG's. Due to a combination of changes in medical technology and the incentives of DRG reimbursement, home health agencies are receiving more Medicare referrals than ever before. A report prepared by the U.S. Senate Special Committee on Aging found that 37 percent more patients were being discharged to home health agencies than prior to the implementation of the DRG's.[2] A study in Washington State, pre- and post- DRG's, found a 27 percent increase in home visits in urban areas.[3]

Accompanying the rise in referrals is an increase in the acuity of the average Medicare patient seen by home health agencies. Patients who several years ago were discharged to home health agencies seven days after an operation are now being discharged after only three days. Home health agencies now routinely provide care which was formerly provided only in the hospital. Examples include the administration of Amphotericin, a type of Intravenous Therapy and epidural catheters for pain control. The increase in acuity can be documented by examining inpatient acuity scales of patients discharged to home health care. As a result of the increased acuity of patients, the patients require more visits and more time per visit. One study found the number of skilled nursing home visits increased 196 percent pre- and post- DRG's.[4]

## III. HCFA is Restricting the Medicare Home Health Benefit

At the same time HCFA policy in the form of DRG's is encouraging earlier discharge of Medicare patients at a higher acuity stage, HCFA policy directives and operational problems are making it more and more difficult for home health agencies to care for these patients.

First, HCFA is encouraging its fiscal intermediaries (FI's) to make increasingly restrictive coverage decisions. We are seeing one or two visits arbitrarily being denied on claims and a disturbing rise in claims being denied totally from the start of care. These denials are occurring at established agencies which have provided Medicare home health care for twenty years in the same careful, well-documented manner. They are occurring despite the fact that no changes have been made to the Home Health Agency Manual (HIM-11) which is supposed to define what is and what is not covered care.

Because agencies can no longer determine what HCFA and the FI's will cover, they have become much more conservative in the care they are providing. Many more cases are not admitted to home health care and those that are receive a drastically reduced number of visits per case. In California, based on a survey of our members, the average number of visits per Medicare case has declined from about 15 in 1985 to about 11 in 1986, a reduction of more than 25 percent.

In spite of this very significant reduction in utilization, the denial rate continues to rise. Nationally, in 1985, 3.5 percent of Medicare home health claims had at least one visit denied.[5] In the first quarter of 1986, this rose to 5.2 percent and by the third quarter of 1986 stood at 7.5 percent. In HCFA Region IX (San Francisco), the third quarter, 1986 figure was 10 percent.

Along with more restrictive coverage decisions, HCFA continues to shrink the home health cost base. The cost limits are scheduled to be reduced from 115 percent to 112 percent of the mean on July 1, 1987. This means the allowable cost per visit will increase about 1 percent, far less than the combined effects of DRG's, increased administrative costs due to the Form 485 series, and inflation.[6]

Finally, as this Subcommittee is well aware, home health claims payment cycles have deteriorated seriously due to HCFA policy and operational problems at the FI's. At the major fiscal intermediary in California, 22,000 home health claims were backlogged on December 31, 1986 and the number of claims processed in the fourth quarter of 1986 was only half the number processed in an average quarter. Over the past two years, home health agencies have seen the payment cycle deteriorate from about one week to 30 to 60 days at best and, in many cases, much, much worse.

## IV. Elderly and Disabled Medicare Patients Are Not Receiving Adequate Care

When the forces of reimbursement incentives and technology are pushing in the direction of more home health care and HCFA is restricting what care they will pay for and how much they will pay for it, someone is going to suffer. As I have presented, home health agencies are, of necessity, becoming much more conservative in admitting patients. A recent study by the GAO found that 86 percent of discharge planners surveyed reported difficulties in placing Medicare patients in home health agencies due to current restrictions.[7] Once admitted to home health agencies, patients are receiving about one third fewer visits per case than formerly. While home health agencies primary mission will be to continue to provide care, the inevitable result of current HCFA policy is to reduce access to Medicare home health care.

I would like to provide you with two examples of the types of denials which are occurring. In one case, a 79 year old patient was admitted to a home health agency after two months in the hospital. This patient, with fracture C2 vertebral body, had had multiple surgeries, was in halo traction, and had a large open wound. After several visits, a physical therapist succeeded in getting the patient to ambulate to the bathroom. The case was denied from start of care based on the fact that the patient was not homebound.

The second case involves a 30 year cardiac patient awaiting a second heart/lung transplant. The patient was so ill that they were not a good candidate for the procedure. Home health nursing visits were being provided for cardiopulmonary assessments and in chest percussion. Half of the visits on the claim were denied as not medically necessary. The patient subsequently expired.

These cases are illustrative of the inappropriate coverage decisions currently being encouraged by HCFA. Agencies are suffering, patients are suffering, and in many cases, Medicare will end up paying higher costs as patients are hospitalized or re-hospitalized as a result of the decisions.

## V. Recommendations

### A. Coverage Rules Should Be Clarified

If HCFA has determined that Medicare home health coverage should be restricted, changes to the Home Health Agency Manual should be proposed for public comment. If current provisions of the Manual continue to apply, HCFA should direct FI's to make coverage decisions based on those provisions.

### B. The Home Health Agency Costs Limits Should Be Reviewed

The July 1, 1987 scheduled reduction in the cost limits to 112 percent of the mean should be suspended pending a review of the appropriateness of those limits given the incentives created by DRG's, administrative costs to agencies of billing and coverage procedures, and inflation.

### C. Prompt Payment Is Essential

Home health agencies must receive prompt payment of claims if they are to continue to be able to serve Medicare patients. Home health agencies do not have the working capital of hospitals or skilled nursing facilities. The 30 day payment standard should be applied to all home health claims including those going to medical review. Fiscal intermediaries should be budgeted to enable them to comply with the prompt payment standards.

1. California Hospital Association Insights, August 6, 1986

2. U.S. Senate Special Committee on Aging - "The Impact of Medicare's Prospective Payment System on the Quality of Care Received by Medicare Beneficiaries", October, 1985

3. "Community Services Burdened by DRG's", The Coordinator, October, 1985, p. 32

4. "Community Services Hit Heavy by DRG's", The Coordinator, October, 1985, p. 31

5. Home Health Line, June 23, 1986, P. 218

6. V. Judith Thomas, "An HHA Prospective Payment Proposal", American Federation of Home Health Agencies, 1986, P. 24

7. U.S. General Accounting Office, Post-Hospital Care: Discharge Planners Report Increasing Difficulties in Placing Medicare Patients, January, 1987, P. 1

Chairman STARK. I thank all of you.

I have just a couple of comments. Bruce, you hit on what I think is essential, if I heard you say, did we think ProPAC should begin to look at some definitions. Secretary Ball, I think, had an article over the weekend saying long-term care is not much of a problem in paying for it if you can identify it. For the panel, I see several problems. I don't see much of a problem if a physician, say, identifies somebody who needs skilled nursing cares or needs an extended stay in the hospital. I think we will buy that and say, Okay, if we can afford it, that is easy; that is a definition that we would accept.

The other definitions, all of a sudden, get very complex. It is the same thing. California is blessed with a guy named Swope, a man with the mind of a piranha fish and the heart of a Doberman pinscher. [Laughter.]

But he has been in charge of Medi-Cal and welfare since Reagan was Governor, and he is concerned, and rightly so, with welfare cheats. As a matter of fact, he is obsessed with welfare cheats and is convinced that everybody on welfare is basically a cheat or the anti-Christ incarnate.

But, at any rate, he is right because there is a guy like me, and I could game the system. Let's say that I contribute, and I really don't, but let's say for public record that I contribute 10 grand a year to help my aged mother live. Well, the minute that I can talk Mr. Donnelly into voting for 22,000 bucks a year for nursing home care, that means Mom gets 21 squares a week and a free color television set in the club room and clean sheets. That is better than I am providing, and I would find a way to game her into that system and take the 10 grand that I am now spending to buy my condo at Lake Tahoe, and I will bet there is a whole heck of a lot of greedy kids out there like myself.

Then you have got the person like Congressman Donnelly. He is not sick; he just can't quite get over to tie his shoes, and we have to find a way to help him get through the day.

What we are going to be faced with is definitions: what do you do with a guy any age who gets laid off, either in Congress or at the UAW, and is unemployable and has to wait a few years until he is 62 to collect anything? He says, Geez, my back aches; I think I am disabled. And when he finds out he can get $800 a month if he is disabled, he thinks that so hard that he probably can disable himself. Then we get into this thing of too much Social Security disability. A person wants it, and it is a lot more dignified to live that way than on general assistance.

You have just opened up that Pandora's box. The insurance is not so bad if we just sort out those people who really need extremely complex custodial care.

One other problem—and I say this not in a pejorative sense but I just say it, and with particular reference to my home State—we have the ability—and you used the word "ambulate," Ms. Andre—we have the ability to obfuscate and complicate and overregulate every darn thing we do in California. I don't care whether it is day care centers, which I once tried to organize. You know, it is very hard to regulate tender, loving care or human kindness, but California tries. [Laughter.]

By golly, there is a wonderful tradeoff. Insisting on professional care and cleanliness is one thing. But, all of a sudden, we can build a bureaucracy of regulators. We can make knitting a profession. We can give degrees in it in our junior colleges and then we can set up a State board of knitting examiners. I worry that we may, as we try to find some way to help these senior citizens, also go too far on the side of regulating.

But it is a problem we are not going to address this year because the money is so great. But if we could start to lay the groundwork of who the gatekeepers will be and how they will operate, it will be a lot easier as we move ahead to provide these services most needed. And we are going to have to ration them, and in rationing, I guess we hope we can be as humane as we can. It is very scary, and I think you have just touched the tipped of the iceberg today. I appreciate it, and I hope you will all go back and stew more on how you can help us as we need these details.

Yes?

Ms. CHELIMSKY. I wanted to make a comment about definition really to echo what some people have said here already. One of the things that we saw was that the benefits are not being applied consistently, and when you go back and look at those guidelines, the definitions just lend themselves to that inconsistency.

It seems to me that there is not only the fact that some people are not getting services that they need, but some people are getting services that they should not be getting. I think there should not be that kind of inconsistency in the guidelines, and it seems to me that is one thing we can look at.

Look at the way intermittent or homebound services are defined apparently—people in some cases have not been considered homebound because they had to go and get a dialysis treatment.

The definitions are vague, and it seems to me that, without getting into the enormous bucket of money for long-term care, there are some limited things that one could consider for beneficiaries rather than for insurance companies; in other words, I would not really go toward copayments and fixing deductible——

Chairman STARK. Hold your hand up when you say that. [Laughter.]

Ms. CHELIMSKY. No, I am keeping it down—but basically toward doing something for beneficiaries.

Mr. VLADECK. Mr. Chairman, could I make a couple of comments on what you said?

Chairman STARK. Please.

Mr. VLADECK. Fundamentally, I think you are quite right in noting that the question of what is a long-term care service and who needs it, and who needs it that ought to be paid for partially at public expense, is one where there is not very much science at the moment, and that is part of our problem.

However, a couple of things, if I may. First, we have a lot of evidence now that while the situation relative to home care may be different, families do not take advantage of the financial incentives implicit in nursing home placement. If anything, the data is pretty good and pretty strong that they overcompensate in the other direction; that is, they hold out longer than is probably desirable

from a clinical or service point of view for the elderly person as well as for the caretaker.

I think, for a variety of reasons, it is important to be careful about the myth that lots of old people are in nursing homes because the family is better off financially as a result. Most of them these days are pretty sick.

Chairman STARK. No, I am not suggesting they are better off financially, but I am suggesting that if you have got 15 million of our Medicare beneficiaries whose income is less than 10 grand and about 8 million of them whose income is less than 6 grand, how can they live on that? I mean, you can't eat.

So if you move into California where we regulate the quality of meals, for better or for worse, and clean sheets and recreational activities, it could look attractive to move from a cold-water walkup flat that you have trouble walking up the stairs to get to and eating tuna fish and then cat food the last few days of the month; it could look awfully attractive to move there. That is what I am suggesting.

Mr. VLADECK. Again, I think the experience and the data does run counter to that, by and large, in the case of nursing home care. It has been suggested that, in the case of long-term home care, then you are getting something for nothing in a sense, and that may be more of a problem. I do not think, really, that is so much a problem with nursing homes.

Second, on this issue of definition of benefits, I think this concern for financial risk to the Federal Government is a very real one, and I would not minimize it. But much of what you heard in this panel has to do with benefits that were enacted in law some time ago, that have been promised to Medicare beneficiaries for a generation, and that are gradually being withdrawn by administrative action, taking advantage of the uncertainties and lack of scientific expertise about definition.

I would only suggest that, for the first two decades of the Medicare program, if you thought there were any terribly scientific criteria about who got admitted to a hospital as an inpatient as opposed to who needed home care, it is not that radically different. But there has been an opportunity, in a climate of cutting every conceivable dollar out of Federal expenditure, to take advantage of ambiguity and lack of scientific basis in definition, to really take something away that used to be there for beneficiaries, and I think that is a relevant issue for short-term consideration, without sliding down the whole slippery slope of long-term care fights.

Ms. CHELIMSKY. Hear, hear.

Ms. ESTES. Mr. Chairman?

Chairman STARK. Yes?

Ms. ESTES. On the same topic, we do have a model of the Canadian health care system, with very inspiring long-term care benefits at the provincial level. Now, that is possible for several reasons. One of them, of course, is that Canada does not have the equivalent of 17 percent of its population—the 35 million we have in the United States—with no health insurance whatsoever so that the Canadian provinces do not have to pay for health care for the poor—uncompensated care—as State and localities have to do in the United States.

But Canada has instituted careful means of control to assure those with the most severe illness receive long-term care, but it is on an entitlement basis and a premium basis, although the different provinces offer different types of long-term care coverage. But the nursing home rates have not gone up as a result of that, and I think the evidence there indicates that there are means to provide the screening to assure that older people who really need long-term care are eligible to receive the appropriate level of care that they require across a range of long-term care services, provided at a cost that government and the public can afford.

Chairman STARK. That is the only reason I can think of that I pray that Margaret Thatcher succeeds, that we might show some people that a national health service can survive in a right-wing-dominated government. [Laughter.]

Mr. Donnelly?

Mr. DONNELLY. I think I just only have one question. It has been a long hearing but very informative and productive, I think.

But won't the issue of the sicker-but-quicker discharges be solved somewhat by the adoption of an acute care catastrophic program?

Mr. VLADECK. No, but I think it is solved already by the recognition of two things: one, that you have to police and monitor and that there has to be an expanded investment in the administrative end of that; and second hospitals are starting to figure out that they are not making any money out of sicker and quicker, and they are at risk for adverse local publicity as a result as well as getting patients and their families mad at them.

Medicare lengths of stay are now going back up. If you look at case mix change, holding the kinds of patients constant, length of stay is not going back up, but it has pretty much stopped falling.

My own sense is that, while there were some really serious problems in 1984 and 1985, we will look back at that 10 years from now and say this was a short-term overreaction to people's perception of something. Like many of these needs of problems, it may pretty well resolve itself.

The fact is, however, that, pre-PPS, it was estimated by the association of PRO's that 5 to 7 percent of all Medicare days were being spent by patients on alternate care, patients who, even under the pre-PPS rules, were determined by PSRO's not to belong in the hospital any more and to need nursing home or home health services. And that is Carroll's no-care zone. The fact of the matter is that those folks were not receiving acute care services when they were in acute care beds pre-PPS.

Now the hospitals, instead of making money off them, are at risk of losing money off them. They are trying to get them out. The services for them are contracting in the community, and that problem remains. But I think it is in many ways a very similar problem to what we used to have. I remember, in 1979 and 1980, when the PRO's were talking about this very serious problem, and it is still very much the same problem.

Ms. ANDRE. If I could also comment, I don't mean to imply by quicker-and-sicker that patients are being put out inappropriately or unable to be cared for adequately at home; simply that the kind of technology and the kind of care that is now appropriate to provide at home has changed drastically over the last several years

and that, if there are not support systems in the home such as nursing care to support a patient, let's say an 80-year-old patient coming home on intravenous (IV) antibiotics and her 80-year-old husband administering the antibiotics who may have not seen an IV before except for this hospitalization, it is not to say the person cannot learn; it is not to say it is inappropriate.

It is to say that they do need some support, some teaching, and some assistance to maintain that safely and adequately at home so that the patients may continue to come home sicker because of the technological advances, but they need the support at home in order to be able to be safe in their care in the home.

Mr. DONNELLY. Dr. Estes, your analysis and study to me argues for needs-testing Medicare. I mean, why should somebody who is living on $6,000 a year versus someone living on $25,000 a year have to pay the same 9.1 percent? For somebody on $6,000, it makes a lot more impact than somebody living on a big, fat pension of $40,000 or $50,000. Do you agree the program ought to be needs-tested?

Ms. ESTES. I agree that services, ought to be offered to those who need them, and in a period of austerity, they ought to be provided to those who need them most. I believe that Medicare, as Social Security, is on a social insurance principle, and I believe in that principle, which entitles all persons in the class—that is, elderly—to health care services.

Mr. DONNELLY. So everybody pays the same no matter what their assets or financial situations.

Chairman STARK. Part of that, doctor, if the gentleman will yield, is not exactly true. Part A, the hospital part, is like social security, but there is this fine difference. It is begging your question, because I think people presume it is the same, but, theoretically, under part B, they are paying 25 percent of the care, but I think——

Mr. DONNELLY. Does anybody think that we ought to needs-test? I mean, if we are going to deal with the enormous cost down the line for health care for our elderly, whether it be acute care or long-term care, is anybody on this panel willing to bite the bullet and say we are going to have to needs-test this program because there are disparaging income classes among the elderly in this country?

[No response.]

Chairman STARK. That is why they are supporting the tax-the-actuarial-value concept.

Mr. VLADECK. Mr. Donnelly, if I may, I would suggest that, for non-Medicare-covered services, we now have a bizarrely means-tested way of getting them, which is use up all your assets, and if your income is below a certain level, we will pay 100 percent.

Mr. DONNELLY. Exactly.

Mr. VLADECK. And that strikes me as irrational. If we begin to try to rationalize how we finance long-term care services, you get in all your Federal-State relations issues as well. But I think you can make a case for some kind of income-related or capacity-to-pay-related premium structure for additional services just as the chairman has talked about a capacity-to-pay consideration in paying an additional premium to cover some of the catastrophic expense.

For the basic Medicare benefits, you do much greater justice, it seems to me, if you address it as a revenue question in terms of the loss of progressivity in the Federal income tax rather than addressing it as a question of means-testing on the benefit side.

Mr. DONNELLY. We lost that last year.

Chairman STARK. Do you want to cosponsor the bill?

Mr. DONNELLY. I am mumbling so that it doesn't go on the record. [Laughter.]

Thank you.

Ms. ESTES. Medicare is also regressive in terms of the flat-rate premiums and out-of-pocket payments because of the inverse relationship between income and percent——

Chairman STARK. I would just suggest to all of you that that will be the topic on March 3. Tune in then. On March 2 we will have Phys PRC, an exciting day of hearings there, and so stay tuned for further developments.

Thank you. Thank you all for your patience today and for helping us. We will look forward to working with you more.

The subcommittee stands in adjournment.

[Whereupon, at 1:37 p.m., the hearing was adjourned.]

[Submission for the record follows:]

STATEMENT OF THE AMERICAN HEALTHCARE INSTITUTE

Mr. Chairman, on behalf of the American Healthcare Institute which represents over 30 non-profit, multi-hospital and health systems in more than 40 states, I would like to present for the record our comments concerning the financial experience of hospitals under the Medicare prospective payment system and in particular the relationship of payments to hospital costs.

From the beginning, the prospective payment system for hospitals has been expected to serve two major objectives—first, to slow the overall growth in expenditures by the Federal government for hospital care provided to Medicare patients; and, second, to change the financial and other incentives of hospital managers. Experience with cost-based reimbursement and its attendant regulations failed to reward providers for cost containment and offered inappropriate incentives for increasing expenditures. The prospective payment system was designed to take account of these defects by setting hospital payments in advance and placing facilities at financial risk for the provision of needed services. By giving hospitals due notice of a fair price in advance of the provision of services, the opportunity to realize a surplus or a loss was made a key part of the strategy to improve the efficiency of the delivery system.

Historically, as you know, hospital costs rose faster than those in many other industries. However, as the Health Care Financing Administration has reported, there has been a remarkable turnaround in the use of hospital facilities since 1979. Moreover, during 1984 and 1985, hospitals took especially aggressive steps to bring their costs under control. As a result of efforts to reduce staffing, purchase more prudently, and provide care in the most economical settings possible, some hospitals were able to produce positive margins in connection with care provided patients, including Medicare beneficiaries. Achieving these economies can be seen in the reductions in the numbers of hospital employees, in fewer admissions, shorter lengths of stay, and in other measures of hospital performance.

In the years since the inception of the program, growth in hospital expenditures under Medicare has slowed dramatically. Meanwhile, federal policy has continuously reduced the payment amounts by sharply limiting the annual update to DRG rates and by reductions in payments for graduate medical education and capital costs. The original provisions of law guaranteeing payment increases at the level of hospital cost inflation plus an allowance for new technology have essentially been repealed.

While hospitals embraced the idea of prospective payment and the risks that go along with it, what we now see being proposed is a prospective pricing system with retroactive adjustment features that penalize hospitals for doing what hospitals were asked to do under Medicare—control costs. We are returning to the old princi-

ples of retroactively determined cost-based reimbursement. We are opposed to this reversal of Medicare payment policy.

We recognize the need to reexamine, from time to time, Medicare DRG payment amounts on the basis of more current data. Changes in technology, in the scope of services provided, and advancements in diagnostic and therapeutic approaches to care all require continuous collection and analysis of new data. Yet, in view of the circumstances outlined above, there are several compelling reasons why current DRG rates should not be cut across-the-board.

Congress has already fully adjusted for the relatively high Medicare margins of the first two years of PPS by sharply constraining the annual update factor. Much of the correction for possible errors in the data base used to initially set the rates and even a Federal recapture of savings from initial hospital behavior changes have already been accomplished.

In the last two years (1986 and 1987), the Medicare update adjustment has been reduced well below the market basket measure of hospital costs. At the same time, policy changes affecting capital, graduate medical education, periodic interim payments, and other payment policy changes have meant additional cutbacks in Medicare payments. Before any final conclusions are reached, and before payments are cut still further, we should examine carefully the actual experience of hospitals as a result of these payment modifications.

There are also major problems with any analysis of the hospital industry's financial condition based only upon an examination of industry-wide averages. Average Medicare margins do not reflect the overall margins of institutions, taking account of all patient care revenues and expenses of the facilities. In fact, industry-wide overall patient care margins of hospitals are on average in fiscal year 1986 about one percent. These data are more indicative of hospital financial status since they reflect the financial experience of providing services to all patients—not just a mechanical calculation of Medicare's payment against Medicare's own very limited definition of costs.

Second, the use of industry-wide averages for purposes of drawing conclusions about individual hospitals or even groups of hospitals is also meaningless. The average does not reflect the range of margin experience of individual hospitals and thus hides the extent to which many hospitals are at or below a break-even point financially on their Medicare cases. For example, ProPAC data for the first year of the PPS system (1984) show that 10% of all hospitals had *Medicare losses* of at least 5%, while 25% of small, rural hospitals had costs at least 3.5% higher than their Medicare revenues.

In essence, these statistics bear out what one would expect to observe under a prospective payment system like Medicare's. In any given year, some institutions are able to realize a surplus on their Medicare cases, while in other years they may very well lose money. Futhermore, some hospitals are suffering year after year. What is more alarming is that the trends in the data suggest that more and more hospitals than ever are now unable to meet their costs for treating Medicare patients.

Finally, it is well to keep in mind that there is also a considerable lag in the availability of current data on hospital financial performance. As a result, all of the recent reports on hospital margins rely on estimates of experience under the program for 1985 or prior years before the freeze in rates in 1986 and other constraints. Furthermore, estimates derived from these data are subject to substantial error as they are based on assumptions about hospital behavior, inflation, case mix, the reliability of cost reports and a host of other variables. Without more recent information about Medicare financial experience, it does not seem prudent to proceed with undifferentiated, sharp across-the-board reductions in Medicare payment rates.

If new cost data (e.g., 1984) are used as the basis for DRG rates, then the inflation of those data for use in future periods must more closely reflect the economic and other factors that determine the actual costs of caring for the Medicare patient. The use of a newer cost base combined with updates—artificially constrained to meet federal budget targets—will not yield payments that are equitable or sufficient.

By way of summary, PPS prices have already been reduced to recapture for the government savings achieved by hospitals from financial and behavior changes that have occurred since the inception of the program. Further across-the-board cuts to meet today's federal budget targets will threaten to undermine the system and erode the confidence of hospitals in the government as a reliable partner. Average hospital margin data from past periods mask the performance of individual institutions and are not reflective of current conditions. On an individual basis, hospitals should be allowed the possibility of earning a surplus on Medicare cases commensurate with the risks inherent in the prospective payment system.

We do not believe that Medicare payment policy can have it both ways. If we are to have prospectivity in payment, then retroactive cost-based adjustments to rates will sap the system's incentives to provide the most economical care consistent with the standards of quality that all of us expect in our health care delivery system.